SERFF Tracking Number:	*AMNA-127992033*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*10498*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*10498*		
Project Name/Number:	*10498/10498*		

Filing at a Glance

Company: American National Insurance Company

Product Name: 10498	SERFF Tr Num: AMNA-127992033	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L08.000 Life - Other	Co Tr Num: 10498	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Tyra Reed, Amber Adams, Tobie Brink	Disposition Date: 02/09/2012
	Date Submitted: 02/06/2012	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: 10498	Status of Filing in Domicile: Pending
Project Number: 10498	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 02/09/2012
	State Status Changed: 02/09/2012
Deemer Date:	Created By: Tobie Brink
Submitted By: Tobie Brink	Corresponding Filing Tracking Number:

Filing Description:

January 31, 2012

Arkansas Insurance Department
Compliance ©\ Life and Health
1200 West Third Street
Little Rock AR 72201©\1904

RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:
10498-AR- Application for Individual Life Insurance

SERFF Tracking Number:	*AMNA-127992033*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*10498*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*10498*		
Project Name/Number:	*10498/10498*		

SERFF Tracking Number: AMNA- 127992033
Company Tracking Number: 10498

Dear Reviewer:

Please find attached the above listed form for your department¡¯s review and approval. This form is a new form and will not replace any previously approved forms.

10498-AR is a simplified issue life application. The recognized market where the application will be used is: direct mail and bank market. The application will be used to apply for previously approved individual simplified issue term life and whole life products. Currently, the application will be used to apply for the following policies:

Form LCT09DM(10) ¨C approved 1/11/2010 SERFF Tracking Number AMNA-126425223
Form LNCT09DM(10) - approved 1/11/2010 SERFF Tracking Number AMNA-126425223
Form RCT09DM(10) - approved 1/11/2010 SERFF Tracking Number AMNA-126425223
Form NPWL09DM(10) ¨C approved 2/17/2010 SERFF Tracking Number AMNA-126484400

Within the application¡¯s Authorization to Obtain, Release and Disclose Medical Information and Agreements section, the applicant is asked to acknowledge their receipt of the Exchange of Information Notice, which contains Medical Information Bureau (MIB, Inc.) and Fair Credit Report Act (FCRA) information. This notice is provided as a part of the solicitation materials and is read when the application is taken online/telephone. A copy is left with the applicant.

Additional information/supporting documentation included in this submission is as follows:
-Statement of Variability
-Payment of the required filing fees have been submitted via EFT
-Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

Sincerely,

Tobie Brink
Life Policy Analyst III

Company and Contact

Filing Contact Information

Tobie Brink, Project Coordinator Tobie.Brink@ANICO.com

SERFF Tracking Number:	*AMNA-127992033*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*10498*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*10498*		
Project Name/Number:	*10498/10498*		

One Moody Plaza
Actuarial Product Development
14th Floor
Galveston, TX 77550

409-763-1112 [Phone] 4165 [Ext]
409-766-6933 [FAX]

Filing Company Information

American National Insurance Company	CoCode: 60739	State of Domicile: Texas
One Moody Plaza	Group Code: 408	Company Type:
Galveston, TX 77550	Group Name:	State ID Number:
(409) 763-4661 ext. [Phone]	FEIN Number: 74-0484030	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	1 form - exempt, no policy present @ 50 per form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Insurance Company	$50.00	02/06/2012	56100381

SERFF Tracking Number:	*AMNA-127992033*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*10498*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*10498*		
Project Name/Number:	*10498/10498*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/09/2012	02/09/2012

SERFF Tracking Number:	*AMNA-127992033*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*10498*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*10498*		
Project Name/Number:	*10498/10498*		

Disposition

Disposition Date: 02/09/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMNA-127992033*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*10498*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*10498*		
Project Name/Number:	*10498/10498*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Cover Letter		No
Supporting Document	Statement of Variability		No
Supporting Document	Online Screen Prints		No
Supporting Document	Telephone Screen Prints		No
Supporting Document	Process Summary		No
Form	Application for Life Insurance		No

SERFF Tracking Number:	*AMNA-127992033*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*10498*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*10498*		
Project Name/Number:	*10498/10498*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	10498-AR	Application/ Enrollment Form	Application for Life Insurance	Initial		50.200	10498-AR.pdf

Application For Individual Life Insurance

American National Insurance Company
P.O. Box 696700
San Antonio, TX 78269

Your Details:

Name: _____

Address: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Phone #1: (____)_____ Phone #2: (____)_____

E-mail: _____

Social Security Number: _____ – _____ – _____

Date of Birth: ____ /____ /____

☐ Female ☐ Male Height: ____ ft. ____ in. Weight: _____

Are you a U.S. Citizen? ☐ Yes ☐ No
If 'No', do you have a permanent residence status? ☐ Yes ☐ No

Annual Household Income: ☐ Under $10,000 ☐ $10,000 - $24,999
☐ $25,000 - $49,999 ☐ $50,000 - $99,999 ☐ $100,000+

Marital Status: ☐ Single ☐ Married

Have you smoked cigarettes in the last 12 months? ☐ Yes ☐ No

Occupation: _____

Your Spouse's Details (*if applying*):

Name: _____

Address: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Phone #1: (____)_____ Phone #2: (____)_____

E-mail: _____

Social Security Number: _____ – _____ – _____

Date of Birth: ____ /____ /____

☐ Female ☐ Male Height: ____ ft. ____ in. Weight: _____

Are you a U.S. Citizen? ☐ Yes ☐ No
If 'No', do you have a permanent residence status? ☐ Yes ☐ No

Annual Household Income: ☐ Under $10,000 ☐ $10,000 - $24,999
☐ $25,000 - $49,999 ☐ $50,000 - $99,999 ☐ $100,000+

Marital Status: ☐ Single ☐ Married

Have you smoked cigarettes in the last 12 months? ☐ Yes ☐ No

Occupation: _____

Your Amount of Coverage & Beneficiary:

Plan: _____

Amount (choose one):

☐ **$250,000** ☐ **$150,000**
☐ **$100,000** ☐ **Other: $** _____

Beneficiary: _____

Date of Birth: ____ /____ /____ Relationship: _____

Automatic Premium Loan Provision Requested? ☐ Yes ☐ No

IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☐ No

If 'Yes', name of company and policy number(s) if available:

Your Spouse's Coverage & Beneficiary:

Plan: _____

Amount (choose one):

☐ **$250,000** ☐ **$150,000**
☐ **$100,000** ☐ **Other: $** _____

Beneficiary: _____

Date of Birth: ____ /____ /____ Relationship: _____

Automatic Premium Loan Provision Requested? ☐ Yes ☐ No

IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☐ No

If 'Yes', name of company and policy number(s) if available:

Your Health:

Your Spouse's Health (*if applying*):

1. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?

You ☐ Yes ☐ No

Your Spouse ☐ Yes ☐ No

continued on back...

Your Health:

Your Spouse's Health (*if applying*):

2. Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?

You ☐ Yes ☐ No | **Your Spouse** ☐ Yes ☐ No

3. Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?

You ☐ Yes ☐ No | **Your Spouse** ☐ Yes ☐ No

4. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization? If "Yes", provide details below (dates of treatment, test results, diagnoses, medications, etc.)

You ☐ Yes ☐ No Details: _____ | **Your Spouse** ☐ Yes ☐ No Details: _____

5. Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? If "Yes", provide details below:

You ☐ Yes ☐ No Details: _____ | **Your Spouse** ☐ Yes ☐ No Details: _____

If you have more details, please include them on a separate sheet of paper

Your Payment — choose one:

I/we authorize the collection of premiums for the policy or policies as follows.

1. ☐ Automatic monthly deductions from my checking or savings account.
   (Enclose a voided check when providing checking account and a deposit slip when providing savings account.)
2. ☐ Charge monthly premiums to my: ☐ Visa ☐ MasterCard ☐ Discover ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐/☐☐
   (Account Number) (Exp. Date)
3. ☐ Bill me/us. (Send no money now.)

Agreements and Your Authorization to Obtain, Release and Disclose Medical Information:

I understand and agree: that the answers in this application are, to the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due is paid in full while I am alive and in the same health condition as described above; that if my spouse and I request life insurance on this application that my personal financial and health information written on it will be made part of the policy issued to not only me but also my spouse; and that if I do not agree, I may contact the Company and receive a separate application.

I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, the Medical Information Bureau (MIB) or other organization that has any records concerning health or medical care, advice or treatment provided to me to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s).

I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.

- I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.
- I acknowledge receiving the Exchange of Information Notice.
- **Fraud Warning**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your Signature: X _____ | **Your Spouse's Signature: X** _____

Date: X_____/_____/_____ | **Date: X**_____/_____/_____

SERFF Tracking Number:	*AMNA-127992033*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*10498*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*10498*		
Project Name/Number:	*10498/10498*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachments:
AR Readability Certification.pdf
AR - Certification of Compliance.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: This is not a product/policy form filing.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Cover Letter
Comments:
Attachment:
AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachment:
AR Statement of Variability.pdf

Item Status: **Status Date:**

Satisfied - Item: Online Screen Prints
Comments:

SERFF Tracking Number:	*AMNA-127992033*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*10498*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*10498*		
Project Name/Number:	*10498/10498*		

Attachment:

AR screen shots-customer.pdf

Item Status: **Status Date:**

Satisfied - Item: Telephone Screen Prints

Comments:

Attachment:

AR screen shots-call center.pdf

Item Status: **Status Date:**

Satisfied - Item: Process Summary

Comments:

Attachment:

ANICO Direct Process.pdf

AMERICAN NATIONAL

READABILITY CERTIFICATION

We hereby certify that the following form(s), meet the requirements of the Readability Insurance Policies Act:

Form	Form Name	Scoring(s)
10498-AR	Application for Individual Life Insurance	50.2

Rex D. Hemme
Senior Vice President & Actuary
American National Insurance Company
1/26/2012

tobie.brink@anico.com
Phone: (409) 763-4661 x4265 Fax: (409) 766-6933

AMERICAN NATIONAL

CERTIFICATION OF COMPLIANCE

The Company has reviewed the captioned form(s) below, and certifies that to the best of its knowledge and belief, the form(s) submitted is (are) in compliance with the following:

Rule & Regulation 19
Rule & Regulation 49
ACA 23-79-138 and Bulletin 15-2009
ACA 23-80-206 (Flesch Certification, minimum of 40)

Form	Form Name	Scoring(s)
10498-AR	Application for Life Insurance	*50.2*

Rex D. Hemme
Senior Vice President & Actuary
American National Insurance Company

Tobie.brink@anico.com
Phone: (409) 763-4661 x4265 Fax: (409) 766-6522

AMERICAN NATIONAL

Tobie Brink, Life Policy Analyst III
Product Development – Actuarial
Home Office : One Moody Plaza, 14th Floor
Galveston, Texas 77550

e-mail: tobie.brink@ANICO.com
Phone: (409) 763-4661 x 4265
Fax: (409) 766-6522

January 31, 2012

Arkansas Insurance Department
Compliance - Life and Health
1200 West Third Street
Little Rock AR 72201-1904

RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:
10498-AR- Application for Individual Life Insurance
SERFF Tracking Number: AMNA- 127992033
Company Tracking Number: 10498

Dear Reviewer:

Please find attached the above listed form for your department's review and approval. This form is a new form and will not replace any previously approved forms.

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Form LCT09DM(10) – approved 1/11/2010 SERFF Tracking Number AMNA-126425223
Form LNCT09DM(10) - approved 1/11/2010 SERFF Tracking Number AMNA-126425223
Form RCT09DM(10) - approved 1/11/2010 SERFF Tracking Number AMNA-126425223
Form NPWL09DM(10) – approved 2/17/2010 SERFF Tracking Number AMNA-126484400

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Additional information/supporting documentation included in this submission is as follows:

- Statement of Variability
- Payment of the required filing fees have been submitted via EFT
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

Sincerely,

Tobie Brink

Tobie Brink
Life Policy Analyst III

Statements of Variability

Direct Response Application

10498-AR

Variable fields are as follow. Any state/entity specific deviations or exceptions are included.

Company Address – The application provides an address (Street and/or P O Box, City, State, and ZIP Code) for the company to which the completed application may be mailed. The address for the company is filed as variable material to allow for updates. The address provided will coincide with the appropriate receiving department. Potential alternatives, if any, will need to be provided.

i.e. San Antonio; League City

Amount – Based on the product solicited, the three most popular applied for face amounts (based on experience) will be pre-filled as possible selections. A reasonable range for the displayed amounts would be a minimum of $2,000 and a maximum of $250,000. The applicant is able to choose an amount other than those shown on the application by selecting the "Other" box and filling in the desired dollar amount.

Automatic Premium Loan Provision Requested – The check box to elect the Automatic Premium Loan Provision ("APL") is only applicable to Whole Life products. When the product solicited is a Term product or a Whole Life product that does not offer APL, the "No" check box will be pre-filled. When the product solicited is a Whole Life product that offers APL, both check boxes will be open, allowing the applicant to choose.

Payment Selection – This section will be pre-filled with payment options that vary based on the market. For markets where an inherent payment vehicle is available (relationships with banks, credit card issuers, mortgages, etc…), such financial institution may have preferred language that we are required to use. However, all language will involve the authorization of premium payments to be automatically charged/deducted from the prospective insureds account.

Examples of the basic types of text that will appear are as follows:

For broad market solicitations:

1. ☐ Automatic monthly deductions from my checking or savings account.
   (Enclose a voided check or a deposit slip for the account to be charged.)
2. ☐ Charge monthly premiums to my: ☐ Visa ☐ MasterCard ☐ Discover
   ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐/☐☐
   (Account Number) (Exp. Date)
3. Bill me/us. (Send no money now.)

For bank solicitations: I understand that by signing this application I authorize my premiums to be automatically deducted from my [name of bank] account once the policy is issued. All premiums for this coverage will be automatically deducted monthly from my account until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically charged to my [name of bank] checking account once the policy is issued. All premium payments for this coverage will be automatically charged monthly to my checking account until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically debited from my [name of bank] checking account once the policy issued. All premium payments for this coverage will be debited monthly from my [name of bank] checking account until I instruct otherwise.

For credit card solicitations: I understand that by signing this application I authorize my premiums to be automatically charged to my (name of bank) account once the policy is issued. All premiums for this coverage will be automatically charged monthly to my account, subject to credit approval, until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically charged to my (name of bank) credit card account once the policy is issued. All premium payments for this coverage will be automatically charged monthly to my credit card account until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically debited from my [name of bank] credit card account once the policy issued. All premium payments for this coverage will be debited monthly from my [name of bank] credit card account until I instruct otherwise.

For Mortgage Solicitations: I understand that by signing this application I hereby certify that I have the authority and do so authorize (name of Mortgage Lender) to add my life insurance premium payments to my mortgage payment.

I understand that by signing this application I hereby certify that I have the authority and do so authorize (name of Mortgage Lender) to add my life insurance premium payments to my mortgage payment.

I understand that by signing this application I authorize (name of Mortgage Lender) to bill and collect premium with my mortgage payment.

The above does not represent every possible scenario but serves as examples.

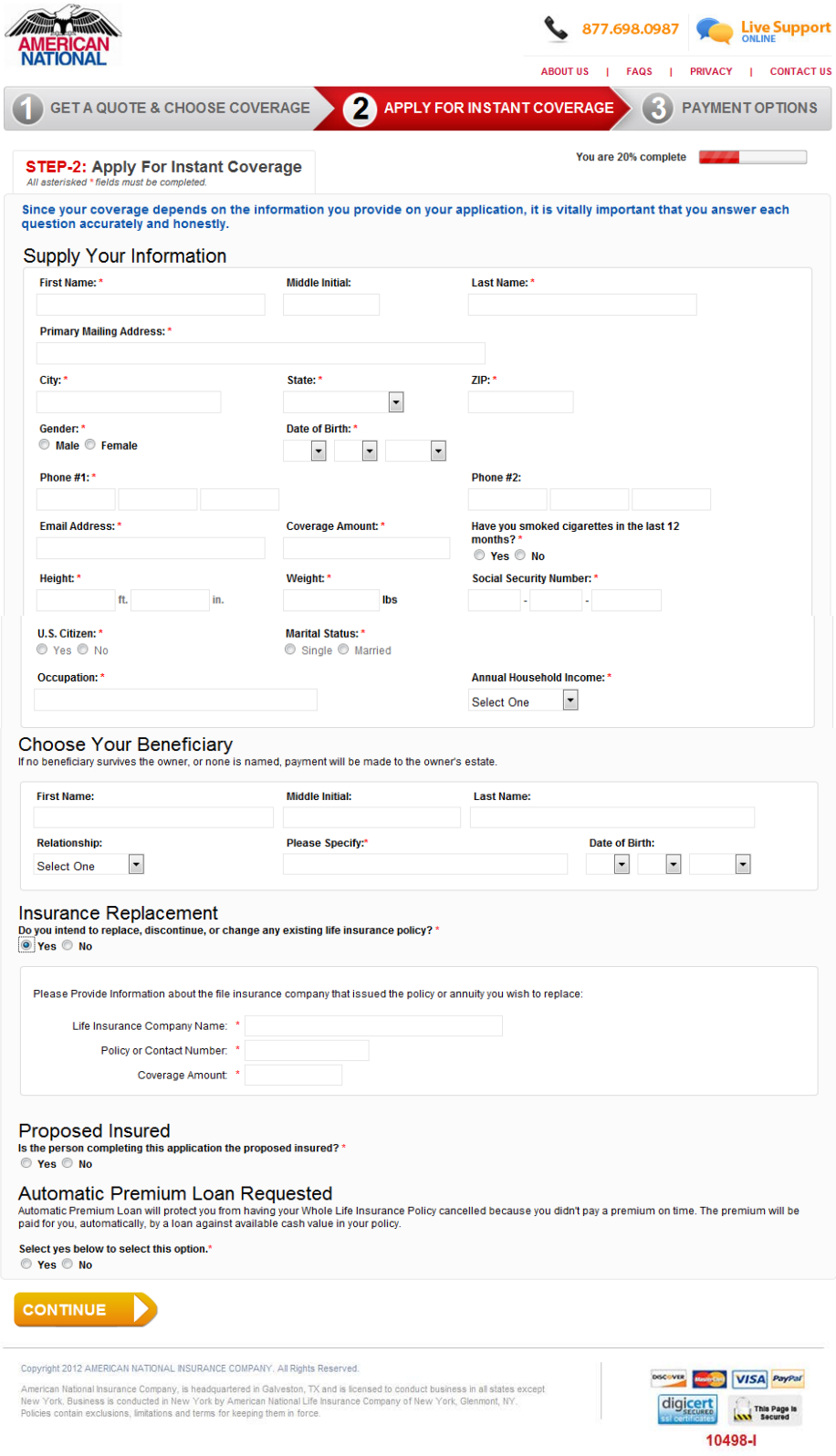
For solicitations where a billing mechanism is not inherent in the marketing, the following options or some combination of the options would be provided:

1. Automatic monthly deductions from my checking or savings account. (Enclose a number deposit slip or voided check.)
2. Charge monthly premiums to my: (checkboxes for each) Visa, MasterCard, Discover (and fields for credit card number and expiration date).
3. Bill me. (Send no money now.)
4. Check Enclosed for my first premium
5. Payment attached for my first premium

CONSUMER DISCLOSURE STATEMENT – Within the Agreements section, the last statement: “I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.” will only appear for those applications produced for the Bank Solicitation channel. The Consumer Disclosure on the Sale of Insurance is contained on the accompanying letter that is provided with the application when the product is solicited via banks and states the following:

-Not Insured by FDIC
-Not a Deposit of or Guaranteed by (Bank Name) or any Federal Government Agency or any (Bank Name) Affiliates.

We certify that any change or modification to a variable item will be administered in accordance with the requirements in the Variability of Information section from the applicable product standards, including any requirements for prior approval of a change or modification.



AMERICAN NATIONAL

877.698.0987 Live Support ONLINE

ABOUT US | FAQS | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE 2 APPLY FOR INSTANT COVERAGE 3 PAYMENT OPTIONS

You are 20% complete

STEP-2: Apply For Instant Coverage

*All asterisked * fields must be completed.*

Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

Supply Your Information

First Name: * Middle Initial: Last Name: *

Primary Mailing Address: *

City: * State: * ZIP: *

Gender: * Male Female

Date of Birth: *

Phone #1: * Phone #2:

Email Address: * Coverage Amount: * Have you smoked cigarettes in the last 12 months? * Yes No

Height: * ft. in. Weight: * lbs Social Security Number: * - -

U.S. Citizen: * Yes No Marital Status: * Single Married

Occupation: * Annual Household Income: * Select One

Choose Your Beneficiary

If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate.

First Name: Middle Initial: Last Name:

Relationship: Select One Please Specify:* Date of Birth:

Insurance Replacement

Do you intend to replace, discontinue, or change any existing life insurance policy? *

Yes No

Please Provide Information about the file insurance company that issued the policy or annuity you wish to replace:

Life Insurance Company Name: *

Policy or Contact Number: *

Coverage Amount: *

Proposed Insured

Is the person completing this application the proposed insured? *

Yes No

Automatic Premium Loan Requested

Automatic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be paid for you, automatically, by a loan against available cash value in your policy.

Select yes below to select this option.*

Yes No

CONTINUE

10498-I

AMERICAN NATIONAL

877.698.0987 | Live Support OFFLINE

ABOUT US | FAQS | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE | 2 APPLY FOR INSTANT COVERAGE | 3 PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage

You are 30% complete

Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

1. Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?
   - Yes
   - No

2. Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?
   - Yes
   - No

   Explain:

3. Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?
   - Yes
   - No

CONTINUE

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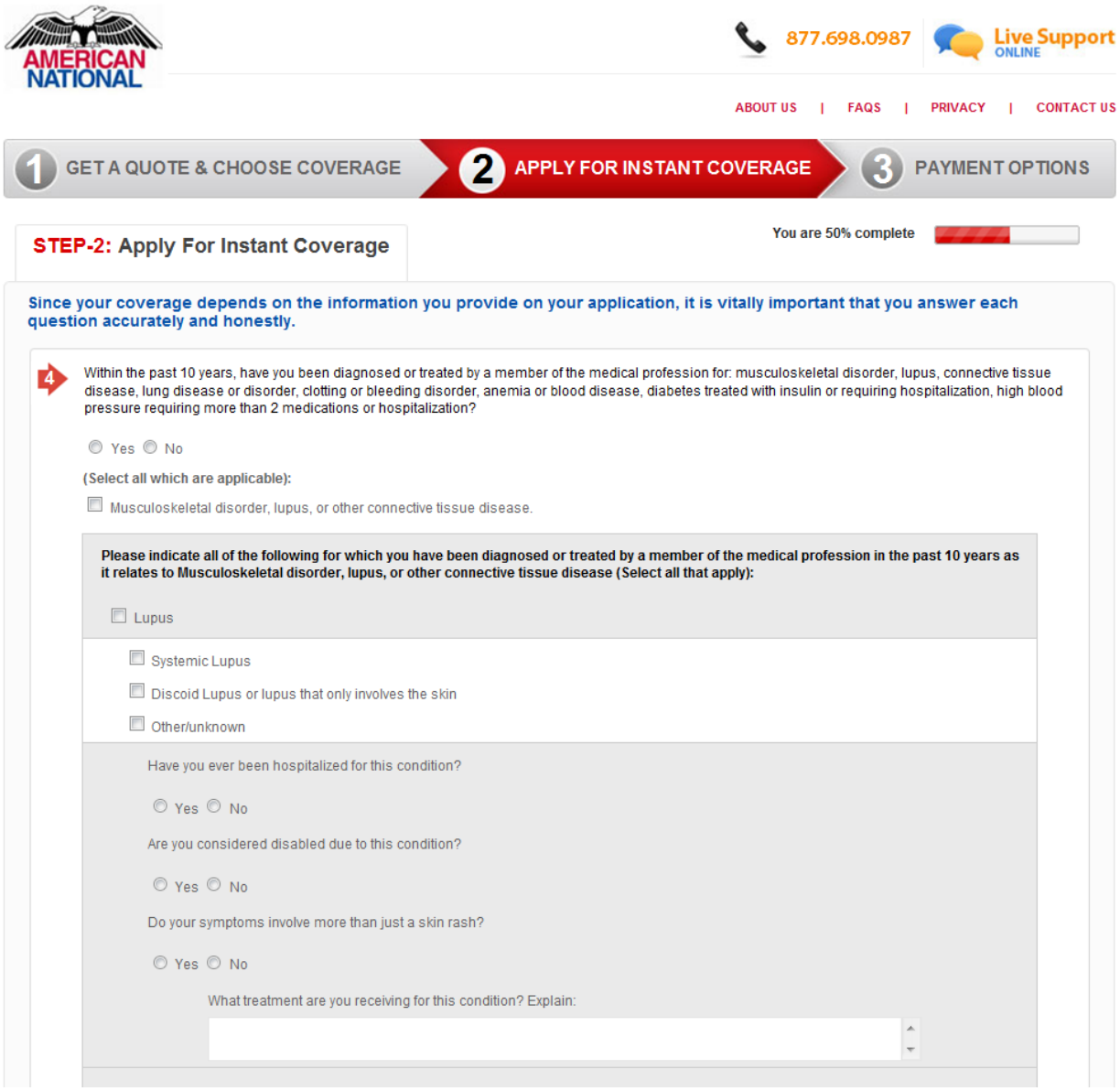
MQ2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Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.
4
Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization?
Yes No
(Select all which are applicable):
Musculoskeletal disorder, lupus, or other connective tissue disease.
Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to Musculoskeletal disorder, lupus, or other connective tissue disease (Select all that apply):
Lupus
Systemic Lupus
Discoid Lupus or lupus that only involves the skin
Other/unknown
Have you ever been hospitalized for this condition?
Yes No
Are you considered disabled due to this condition?
Yes No
Do your symptoms involve more than just a skin rash?
Yes No
What treatment are you receiving for this condition? Explain:

☐ Rheumatoid Arthritis

Are you considered disabled due to this condition?

○ Yes ○ No

Have you ever been hospitalized for this condition?

○ Yes ○ No

Do you require the walking aids or wheelchair?

○ Yes ○ No

Do you take steroids or Prednisone?

○ Yes ○ No

☐ Mixed Connective Tissue Disease

☐ Polymyositis or dermatomyositis

☐ Fibromyalgia

Are you currently being treated with steroids, Prednisone or narcotic pain medication?

○ Yes ○ No

☐ Tendonitis or tenosynovitis

☐ Gout

☐ Osteoarthritis

☐ Osteomyelitis

Is this a chronic condition?

○ Yes ○ No

Have you fully recovered?

○ Yes ○ No

Number of years since your last episode or attack?

○ 0 to 3 years

○ Over 3 years

☐ Herniated disc or back sprain

Do you currently require use of narcotic pain medication?

Yes No

☐ Osteoporosis

Does this condition cause any restrictions on activity or disability?

Yes No

☐ Paget's disease of the Bone

Does this involve more than 2 bones?

Yes No

Has this disease resulted in more than 1 fracture?

Yes No

Are there any restrictions on activity?

Yes No

Are you considered disabled due to this condition?

Yes No

☐ Benign, Non-malignant bone or joint tumor(s)

Have you fully recovered with no evidence of recurrence?

Yes No

Do you currently have any current tumor that has not been surgically removed?

Yes No

When was most recent tumor removed?

0 to 3 years

Over 3 years

☐ Malignant, cancerous bone or joint tumor(s)

☐ Polymyalgia Rheumatica

Have you had any treatment or symptoms within the past 2 years?

Yes No

☐ Other

Explain:

☐ Lung disease or disorder

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to lung disease or disorder (Select all that apply):

☐ Emphysema

☐ COPD (Chronic Obstructive Lung Disease) or Chronic Bronchitis

Have you smoked any tobacco products in the past 2 years?

○ Yes ○ No

Have you ever required oxygen treatment?

○ Yes ○ No

Have you been hospitalized in the past 5 years for COPD or chronic bronchitis?

○ Yes ○ No

Are you currently treated with oral steroids or Prednisone?

○ Yes ○ No

Do you currently have any restrictions on activity due to COPD or Chronic Bronchitis?

○ Yes ○ No

Are you considered disabled due to COPD or Chronic Bronchitis

○ Yes ○ No

☐ Asthma

Have you been hospitalized in past 2 years for asthma?

○ Yes ○ No

Are you treated by oral steroids or Prednisone?

○ Yes ○ No

Do you currently have any restrictions on activity due to asthma?

○ Yes ○ No

Are you considered disabled due to asthma?

Yes No

☐ Bronchiectasis

Have you ever required oxygen treatment?

Yes No

Have you been hospitalized for bronchiectasis in the past 5 years?

Yes No

Are you considered disabled due to bronchiectasis?

Yes No

Do you currently have any restrictions on activity due to bronchiectasis?

Yes No

☐ Bronchitis (non chronic)

☐ Pneumonia

Do you currently have pneumonia, have had pneumonia within the past 3 months or are recovering from pneumonia?

Yes No

Have you fully recovered from pneumonia and have no further symptoms?

Yes No

Have you been advised to have a follow-up Chest X-ray, CT-scan, MRI or other testing related to the lungs that has not been completed or that you are awaiting results?

Yes No

Do you have any other lung or heart problems?

Explain:

☐ Pneumothorax (collapsed lung)

Did the pneumothorax occur within the past 6 months?

Yes No

What was the cause of the pneumothorax?

- ○ Spontaneous
- ○ Trauma
- ○ Other

Explain:

Have you fully recovered from the pneumothorax with no further symptoms?

○ Yes ○ No

☐ Pulmonary embolism (blood clot in lung)

Have you had more than one episode/event associated with a pulmonary embolism?

○ Yes ○ No

Have you had a pulmonary embolism within the past 2 years?

○ Yes ○ No

Do you require ongoing anticoagulant treatment (Coumadin or Warfarin) to prevent future blood clots?

○ Yes ○ No

Was the cause of the embolism due to another disease or disorder?

○ Yes ○ No

Explain:

☐ Pulmonary Hypertension

☐ Sarcoidosis

☐ Sleep Apnea

Were you diagnosed with sleep apnea within the past 6 months?

○ Yes ○ No

Have you been advised to use c-pap or bi-pap treatment?

Yes No

Do you use recommended treatment?

Yes No

Have you been advised to have a sleep study that has not yet been completed?

Yes No

Do you currently suffer from excessive daytime fatigue?

Yes No

Lung cancer

Other

Explain:

Clotting or bleeding disorder, anemia or blood disease

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to clotting or bleeding disorder, anemia or blood disease (select all that apply)

Anemia

Have you been hospitalized for anemia in the past year?

Yes No

Has your anemia caused you to receive a blood transfusion in the past 5 years?

Yes No

Have you ever been diagnosed with cancer (excluding basal cell or squamous cell skin cancer), leukemia, lymphoma, multiple myeloma, or hemophilia or other bleeding/clotting disorder?

Yes No

Have you been diagnosed with sickle cell anemia?

Yes No

Have you been advised by a member of the medical profession that you have sickle cell trait only?

Yes No

Have you ever been diagnosed with symptomatic sickle cell anemia or required any treatment for sickle cell anemia?

Yes No

Was the cause of the anemia due to bleeding from the gastrointestinal tract?

Yes No

Was the last occurrence of gastrointestinal bleeding within the past 2 years?

Yes No

Was there any cancer or malignancy found to be the cause of the bleeding?

Yes No

Have the symptoms fully resolved and anemia no longer present?

Yes No

Have you had a colonoscopy with abnormal results in the past 2 years?

Yes No

Have you been advised to have a colonoscopy or other testing involving the gastrointestinal tract that has not yet been completed?

Yes No

Other

Explain:

Diabetes treated with insulin or requiring hospitalization

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to diabetes treated with insulin or requiring hospitalization (select all that apply)

Have you been prescribed Insulin to treat your diabetes?

Yes No

Have you been hospitalized in the past 5 years due to diabetes?

Yes No

Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?

Yes No

Have you been diagnosed by a member of the medical profession with heart disease, kidney disease, excessive protein or albumin in the urine, or blindness?

Yes No

Have you had any limbs amputated due to diabetes or circulatory problems?

Yes No

Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?

Yes No

What was your most recent Hemoglobain A1c (HGB A1c, glycosylated hemoglobin) test result?

- 7.0 or less
- 7.1 - 9.99
- 10.0 or higher
- unknown

What was your most recent blood sugar test result?

- Below 145
- 145 to 220
- Over 220

Have you been prescribed oral medications or diet to treat your diabetes?

Yes No

Have you been hospitalized in the past 5 years due to diabetes?

Yes No

Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?

Yes No

Have you had any limbs amputated due to diabetes or circulatory problems

Yes No

Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?

Yes No

What was your most recent Hemoglobain A1c (HGB A1c, glycosylated hemoglobin) test result?

7.0 or less

7.1 - 9.99

10.0 or higher

unknown

What was your most recent blood sugar test result?

Below 145

145 to 220

Over 220

High blood pressure requiring more than 2 medications or hospitalization

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to high blood pressure requiring more than 2 medications or hospitalization (select all that apply)

In the past 6 months have you had a blood pressure reading over 160/100?

Yes No

Have you ever been diagnosed with Stroke, Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA), Heart Disease, Congestive Heart Failure, Peripheral Vascular disease, or disease or disorder of the heart valves?

Yes No

Do you have any cardiac testing or procedures pending or advised to have completed that have not been completed?

Yes No

Explain:

5 Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?

○ Yes ○ No

(Select all which are applicable):

☐ Heart attack or any disease or abnormality of the heart or blood vessels.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to heart attack or disease or abnormality of the heart or blood vessels. (Select all that apply):

☐ Heart Attack

☐ Stroke or Cerebral Vascular Accident (CVA)

☐ Coronary Artery Disease

☐ Coronary Bypass surgery, coronary angioplasty, or Stinting of coronary artery or arteries.

☐ Congestive Heart Failure

☐ Disease of the heart valve or valves

☐ Heart Murmur

Does your heart murmur cause any restrictions on activity?

○ Yes ○ No

Have you ever had any blackouts or fainting episodes due to your heart murmur?

○ Yes ○ No

Have you ever been diagnosed by a member of the medical profession with a disease or disorder of the heart valves?

○ Yes ○ No

Have you been diagnosed with Mitral Valve Prolapse (MVP)?

○ Yes ○ No

Does your Mitral Valve Prolapse cause any arrhythmias or palpatations or restrict activity in any way?

○ Yes ○ No

When was your most recent echocardiogram (ultrasound of heart)?

- ○ within the last 6 months
- ○ over 6 months ago
- ○ never had an echocardiogram

Have you been advised to have an echocardiogram (ultrasound of heart) that has not yet been completed?

○ Yes ○ No

Do you have any other cardiac testing or procedures pending or advised to have completed that have not yet been completed?

○ Yes ○ No

Explain:

- ☐ Irregular heartbeat, palpatations, or arrhythmia
- ☐ High Blood Pressure or Hypertension
- ☐ Other

Explain:

- ☐ Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease.
- ☐ Cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy.
- ☐ Acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex.
- ☐ Tested positive on an acquired immune deficiency syndrome-related test.
- ☐ Nervous system disorder or disease.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply):

- ☐ Dementia or cognitive disease or disorder
- ☐ Huntington's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke or Cerebral Vascular Accident (CVA)
- ☐ Parkinson's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease
- ☐ Seizure disorder or epilepsy

Were you first diagnosed with seizure disorder or epilepsy within the past 2 years?

Yes No

When was your last attack/episode of epilepsy or seizure?

0-3 years ago

3-7 years ago

Over 7 years ago

Are you considered disabled due to seizure disorder or epilepsy?

Yes No

Is seizure disorder or epilepsy caused by a brain or other nervous system tumor?

Yes No

Do you have any testing or procedures that have been recommended by a member of the medical profession for seizure disorder or epilepsy that has not yet been completed?

Yes No

Explain:

Tremor

Has the tremor been present for less than 2 years?

Yes No

Has the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no Parkinson's disease or other underlying cause?

Yes No

Do you have any testing or procedures with respect to the tremor that have been recommended by a member of the medical profession that has not yet been completed?

Yes No

Explain:

Spinal Cord injury or disease

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to spinal cord injury or disease (Select all that apply):

- [ ] Quadriplegia or tetraplegia
- [ ] Paraplegia or Paraparesis
- [ ] Hemiplegia or hemaparesis
- [ ] Non-paralyzing injury to spinal cord
- [ ] Spondylosis
- [ ] Herniated disc or compression of the spinal cord
- [ ] Other Spinal Cord disease, disorder or injury

Explain:

Do you currently use a wheel chair?

( ) Yes ( ) No

Do you currently require the use of narcotics to control pain?

( ) Yes ( ) No

Do you currently require walking aids?

( ) Yes ( ) No

Are you considered disabled due to the spinal cord injury or disease?

( ) Yes ( ) No

- [ ] Tumor of the nervous system or brain

Was the tumor considered cancerous or malignant?

( ) Yes ( ) No

Was the tumor a brain tumor?

( ) Yes ( ) No

Has the brain tumor been surgically removed?

( ) Yes ( ) No

Was the brain tumor removed within the past 10 years?

( ) Yes ( ) No

Do you have any neurological testing or procedure that has been recommended by a medical professional that has not yet been completed?

( ) Yes ( ) No

Explain:

Was the tumor a spinal cord tumor?

Yes No

Was the tumor surgically removed

Yes No

Was the tumor removed within the past 2 years?

Yes No

Do you have any neurological testing or procedure that has been recommended by a medical professional that has not yet been completed?

Yes No

Explain:

Depression, Anxiety, or other psychological condition

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to depression, anxiety, or other psychological condition: (Select all that apply):

Bipolar

Schizophrenia

Depression

Have you been hospitalized for this condition in the past 5 years?

Yes No

Have you ever attempted suicide?

Yes No

Are you considered disabled due to this condition?

Yes No

Anxeity

Have you been hospitalized for this condition in the past 5 years?

Yes No

Have you ever attempted suicide?

Yes No

Are you considered disabled due to this condition?

Yes No

Other

Explain:

Bells Palsy

Have you been diagnosed by a member of the medical profession with Bells Palsy within the past 6 months?

Yes No

Trigeminal Neuralgia

Have you had surgery for trigeminal neuralgia?

Yes No

Have you fully recovered from the surgery?

Yes No

Has surgery been recommended that has not been completed?

Yes No

Thoracic Outlet Syndrome

Narcolepsy

Were you first diagnosed by a member of the medical profession with Narcolepsy within the past 2 years?

Yes No

Have you had any symptoms of narcolepsy in the past year?

Yes No

Other nervous system disorder or disease

Explain:

Hepatitis C or any kidney, liver, pancreas disease or disorder.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to hepatitis C or kidney, liver, pancreas disease or disorder. (Select all that apply): :

- [ ] Kidney Disease
  - [ ] Blockage of the renal (kidney) arteries
  - [ ] Hypertensive renal (kidney) disease
  - [ ] Cancer of the kidney
  - [ ] Had dialysis or been advised to have dialysis?
  - [ ] Kidney failure
  - [ ] Glomerulonephritis, nephritic or nephrotic syndrome
  - [ ] Polycystic kidney disease
  - [ ] Kidney stones
  - [ ] Kidney infection
    - Did your kidney infection occur in the past 3 months?
      - ( ) Yes ( ) No
      - Have you fully recovered from your kidney infection
        - ( ) Yes ( ) No
  - [ ] Other
    - Explain:
- [ ] Hepatitis B or C
- [ ] Hepatitis A
  - Have you fully recovered from Hepatitis A?
    - ( ) Yes ( ) No
- [ ] Non-viral hepatitis
- [ ] Enlarged liver
- [ ] Cirrhosis of the liver
- [ ] Primary Biliary Cirrhosis
- [ ] Primary Sclerosing Cholangitis
- [ ] Liver tumor or liver cancer

☐ Fatty liver

Have you been advised by member of the medical profession that your liver enzymes or liver function tests are abnormal or elevated?

◯ Yes ◯ No

Have you been advised by a member of the medial profession that the cause of fatty liver is related to alcohol use?

◯ Yes ◯ No

Have you had a liver biopsy or has a liver biopsy been recommended by a member of the medical profession?

◯ Yes ◯ No

Have you been diagnosed by a member of the medical profession with Non-Alcoholic Steatohepatitis (NASH)?

◯ Yes ◯ No

☐ Pancreatitis

☐ Tumor or Cancer of the Pancreas

☐ Crohn's or ulcerative colitis

Do you use steroids or immunosuppressive drugs for treatment?

◯ Yes ◯ No

Have you been hospitalized for Crohn's or ulcerative colitis in the past 5 years?

◯ Yes ◯ No

Did you require surgery or have you been advised by a member of the medical profession to have surgery for Crohn's or ulcerative colitis which has not been performed?

◯ Yes ◯ No

Have you had an attack of Crohn's or ulcerative colitis within the past year?

◯ Yes ◯ No

Does Crohn's or ulcerative colitis limit normal activity or are you considered disabled due to this condition?

◯ Yes ◯ No

Has a member of the medical profession advised you to have a colonoscopy or other test related to the gastrointestinal tract that has not been completed?

◯ Yes ◯ No

☐ Other

Explain:

☐ Alzheimer's, schizophrenia, bipolar or mental disorder.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to alzheimer's, schizophrenia, bipolar or mental disorder (select all that apply) :

☐ Alzheimer's
☐ Schizophrenia
☐ Bipolar
☐ Attempted Suicide
☐ Depression

Have you been hospitalized for this condition in the past 5 years?

○ Yes ○ No

Have you ever attempted suicide?

○ Yes ○ No

Are you considered disabled due to this condition?

○ Yes ○ No

☐ Anxiety

Have you been hospitalized for this condition in the past 5 years?

○ Yes ○ No

Have you ever attempted suicide?

○ Yes ○ No

Are you considered disabled due to this condition?

○ Yes ○ No

☐ Other

Explain:

CONTINUE

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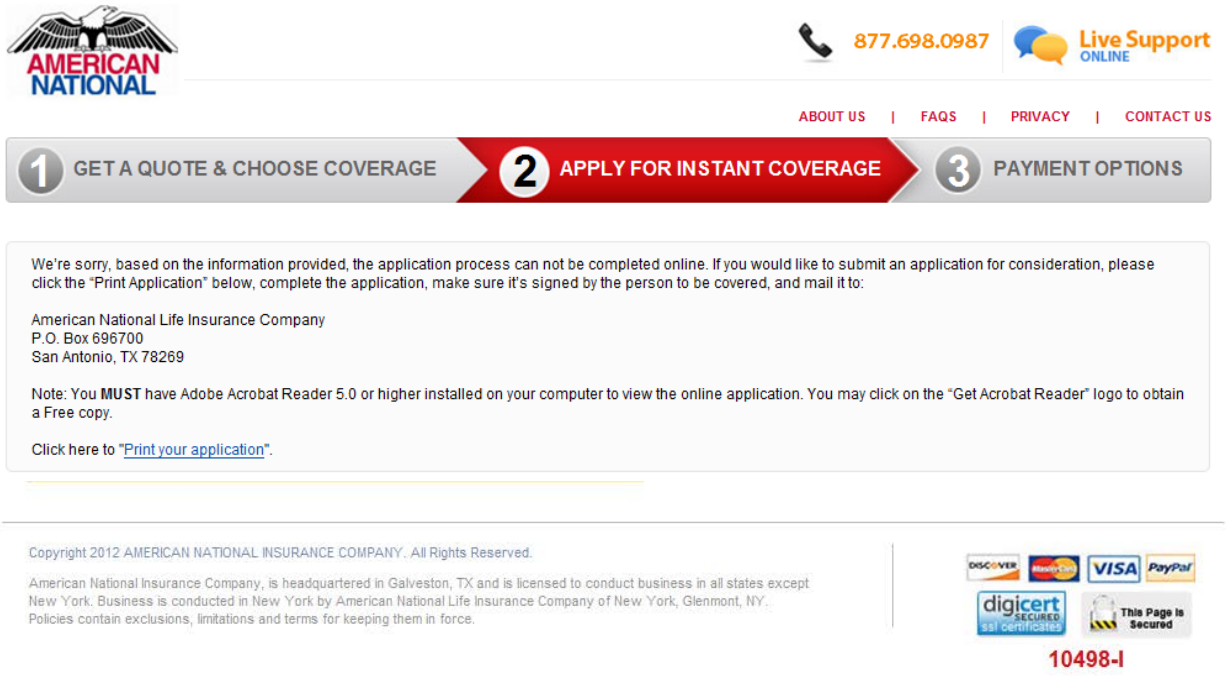

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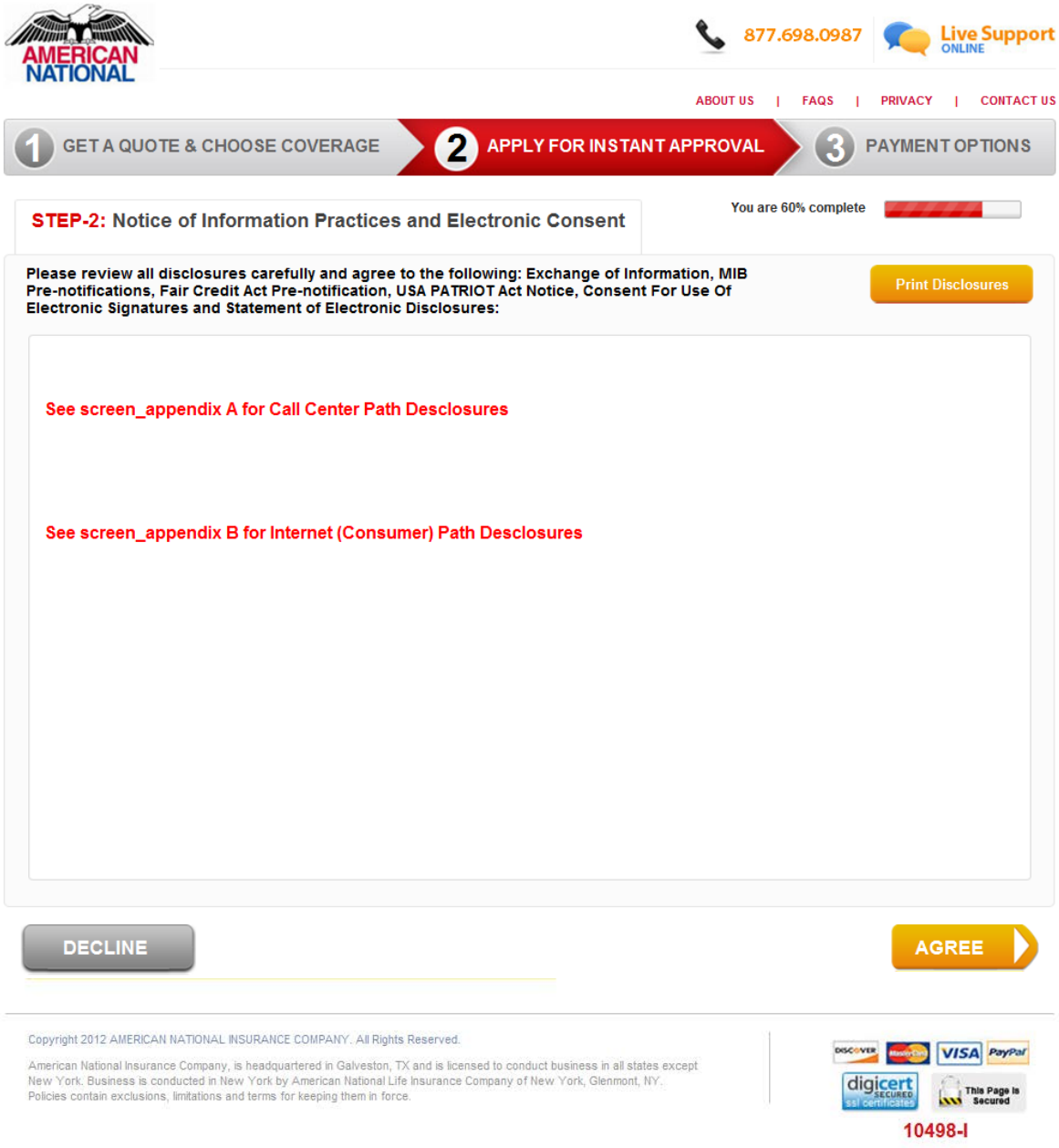

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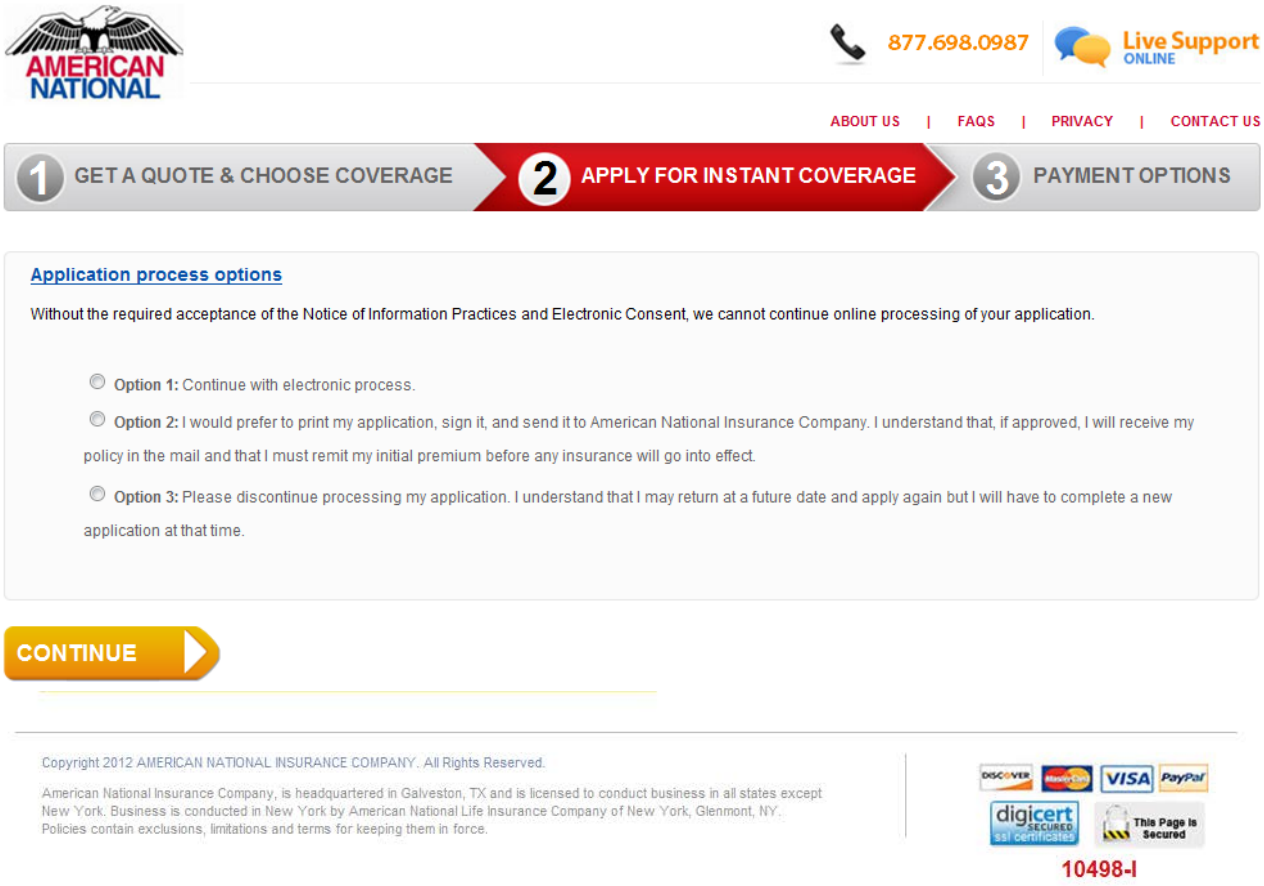

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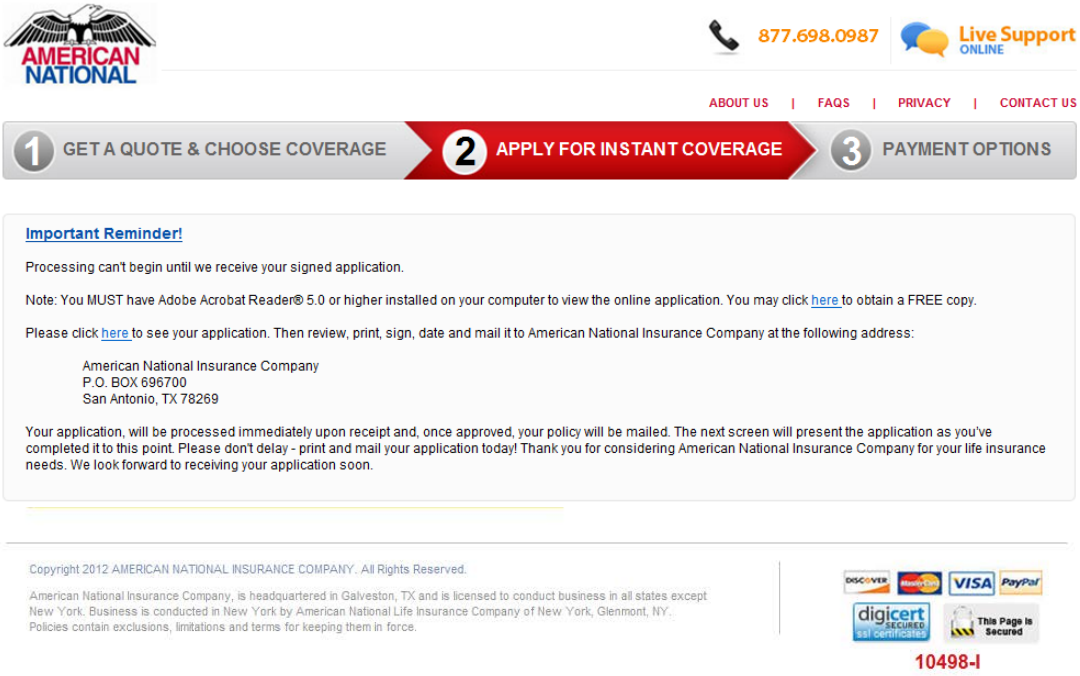
Ex opt 2 –



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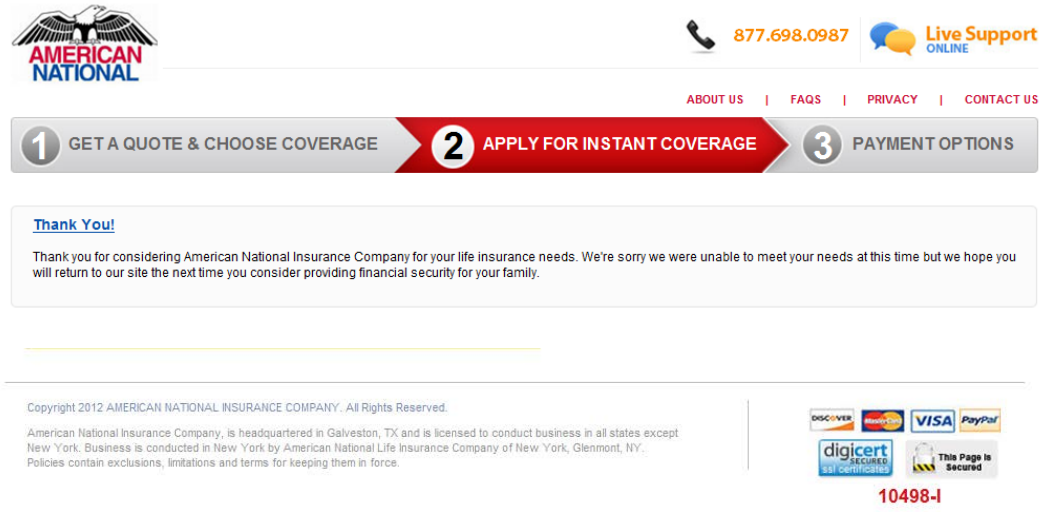
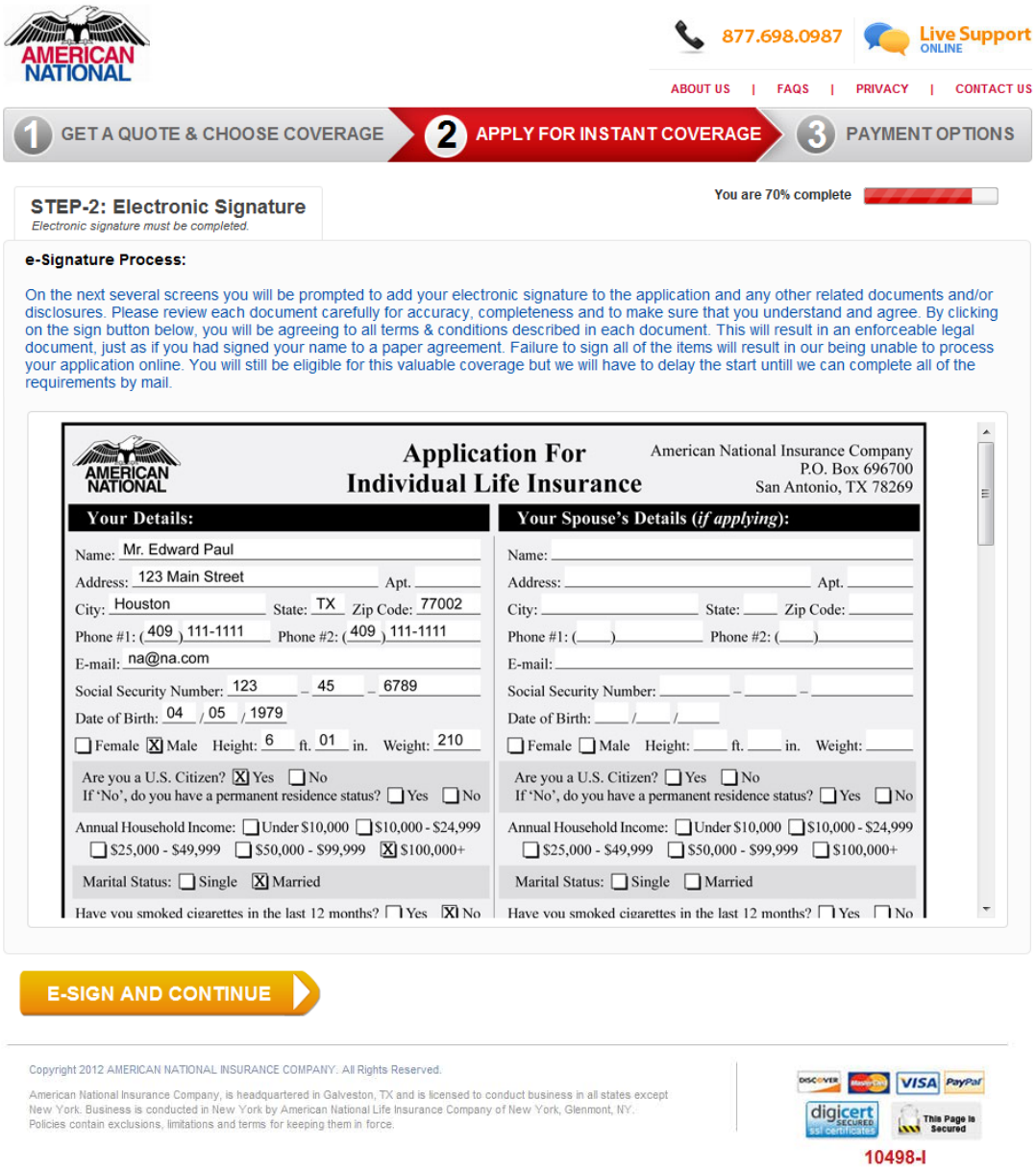


If agree from Disclosure Page – App is scrollable to review entire app (top of app)



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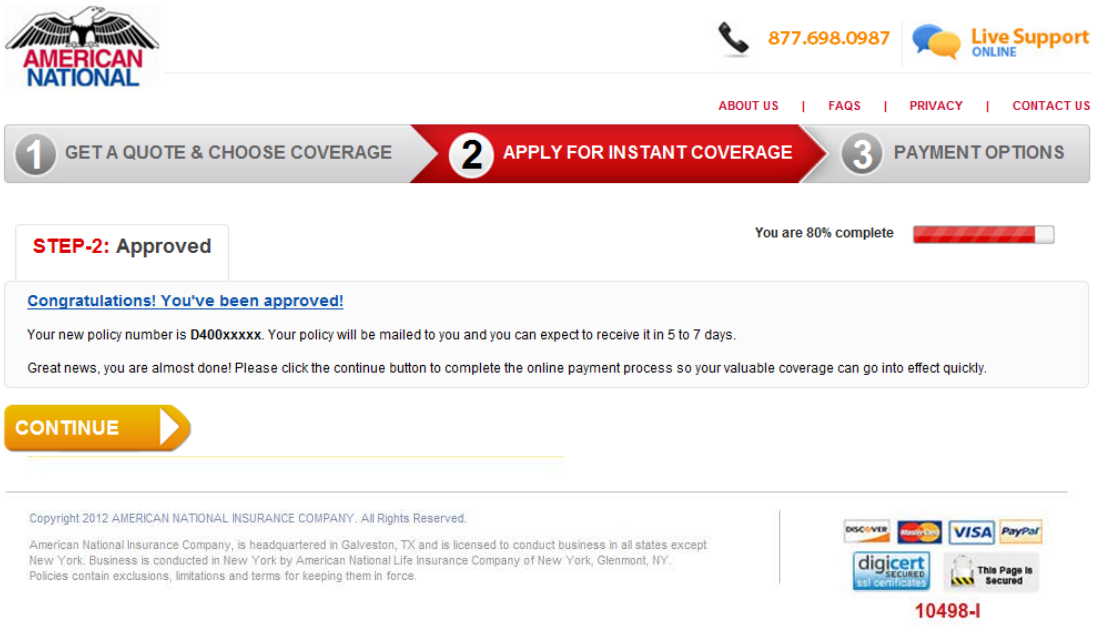
Approve –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You are 80% complete
Congratulations! You've been approved!
Your new policy number is D400xxxxx. Your policy will be mailed to you and you can expect to receive it in 5 to 7 days.
Great news, you are almost done! Please click the continue button to complete the online payment process so your valuable coverage can go into effect quickly.
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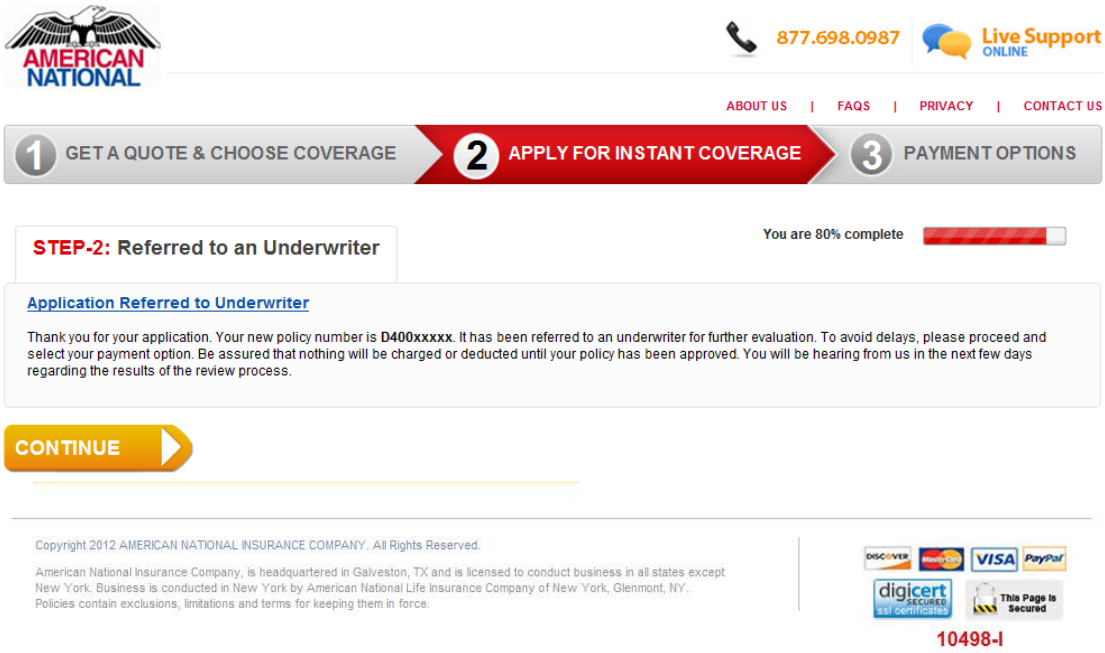
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You are 80% complete
Application Referred to Underwriter
Thank you for your application. Your new policy number is D400xxxxx. It has been referred to an underwriter for further evaluation. To avoid delays, please proceed and select your payment option. Be assured that nothing will be charged or deducted until your policy has been approved. You will be hearing from us in the next few days regarding the results of the review process.
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Final Application signed –

AMERICAN NATIONAL

Application For Individual Life Insurance

American National Insurance Company
P.O. Box 696700
San Antonio, TX 78269

Your Details:

Name: Mr. Edward Paul
Address: 123 Main Street Apt. ____
City: Houston State: TX Zip Code: 77002
Phone #1: (409) 111-1111 Phone #2: (409) 111-1111
E-mail: na@na.com
Social Security Number: 123 – 45 – 6789
Date of Birth: 04 / 05 / 1979
☐ Female ☒ Male Height: 6 ft. 01 in. Weight: 210

Are you a U.S. Citizen? ☒ Yes ☐ No
If 'No', do you have a permanent residence status? ☐ Yes ☐ No

Annual Household Income: ☐ Under $10,000 ☐ $10,000 - $24,999
☐ $25,000 - $49,999 ☐ $50,000 - $99,999 ☒ $100,000+

Marital Status: ☐ Single ☒ Married

Have you smoked cigarettes in the last 12 months? ☐ Yes ☒ No
Occupation: franchise owner

Your Spouse's Details (*if applying*):

Name: ____
Address: ____ Apt. ____
City: ____ State: ____ Zip Code: ____
Phone #1: (____)____ Phone #2: (____)____
E-mail: ____
Social Security Number: ____ – ____ – ____
Date of Birth: ____ / ____ / ____
☐ Female ☐ Male Height: ____ ft. ____ in. Weight: ____

Are you a U.S. Citizen? ☐ Yes ☐ No
If 'No', do you have a permanent residence status? ☐ Yes ☐ No

Annual Household Income: ☐ Under $10,000 ☐ $10,000 - $24,999
☐ $25,000 - $49,999 ☐ $50,000 - $99,999 ☐ $100,000+

Marital Status: ☐ Single ☐ Married

Have you smoked cigarettes in the last 12 months? ☐ Yes ☐ No
Occupation: ____

Your Amount of Coverage & Beneficiary:

Plan: BudgetGuard 7 Year Term
Amount (choose one):
☐ **$xxx,xxx** ☐ **$xxx,xxx**
☐ **$xxx,xxx** ☒ **Other: $** 25,000.00
Beneficiary: Ruth Paul
Date of Birth: 03 / 10 / 1980 Relationship: Spouse
Automatic Premium Loan Provision Requested? ☐ Yes ☒ No

IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☒ No
If 'Yes', name of company and policy number(s) if available:

Your Spouse's Coverage & Beneficiary:

Plan: ____
Amount (choose one):
☐ **$xxx,xxx** ☐ **$xxx,xxx**
☐ **$xxx,xxx** ☐ **Other: $** ____
Beneficiary: ____
Date of Birth: ____ / ____ / ____ Relationship: ____
Automatic Premium Loan Provision Requested? ☐ Yes ☐ No

IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☐ No
If 'Yes', name of company and policy number(s) if available:

Your Health:

Your Spouse's Health (*if applying*):

1. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?

You ☐ Yes ☒ No **Your Spouse** ☐ Yes ☐ No

10498-AR

continued on back...

ADLAXXXX

Your Health:	Your Spouse's Health (*if applying*):

2. Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?

You ☐ Yes ☒ No | **Your Spouse** ☐ Yes ☐ No

3. Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?

You ☐ Yes ☒ No | **Your Spouse** ☐ Yes ☐ No

4. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization? If "Yes", provide details below (dates of treatment, test results, diagnoses, medications, etc.)

You ☐ Yes ☒ No Details: _____ | **Your Spouse** ☐ Yes ☐ No Details: _____

5. Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? If "Yes", provide details below:

You ☐ Yes ☒ No Details: _____ | **Your Spouse** ☐ Yes ☐ No Details: _____

If you have more details, please include them on a separate sheet of paper

Your Payment — choose one:

I/we authorize the collection of premiums for the policy or policies as follows.

1. ☐ Automatic monthly deductions from my checking or savings account.
   (Enclose a voided check when providing checking account and a deposit slip when providing savings account.)
2. ☐ Charge monthly premiums to my: ☐ Visa ☐ MasterCard ☐ Discover ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐/☐☐
   (Account Number) (Exp. Date)
3. ☐ Bill me/us. (Send no money now.)

Agreements and Your Authorization to Obtain, Release and Disclose Medical Information:

I understand and agree: that the answers in this application are, to the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due is paid in full while I am alive and in the same health condition as described above; that if my spouse and I request life insurance on this application that my personal financial and health information written on it will be made part of the policy issued to not only me but also my spouse; and that if I do not agree, I may contact the Company and receive a separate application.

I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, the Medical Information Bureau (MIB) or other organization that has any records concerning health or medical care, advice or treatment provided to me to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.

• I acknowledge receiving the Exchange of Information Notice.

• **Fraud Warning**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your Signature: X E-Signed 01/01/2012 by Edward Paul

Date: X 01 / 01 / 2012

Your Spouse's Signature: X _____

Date: X ____/____/____

Screen appendix B – Internet (Customer) Path

You have now provided the personal information needed to evaluate your insurance application. Before we can complete your application review, we must ask you to read and accept certain disclosures about our information practices and provide us with any necessary authorizations. These disclosures begin below.

Exchange of Information Notice
We are required to provide you the following disclosures to you:

Medical Information Bureau, Inc. (MIB) Pre-Notification
Information regarding your insurability will be treated as confidential. American National Insurance Company, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American National Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification
We may obtain an investigative consumer report in connection with your application. This report may contain information about your character, general reputation, personal characteristics or mode of living gathered from personal interviews with persons who may be acquainted with you. The information is kept confidential.

You have the right to additional information about the nature and scope of the investigation provided you submit your request in writing within a reasonable period of time. We will inform you whether an investigative consumer report was requested and provide you with contact information for the agency preparing the report. By contacting the agency and providing proper identification, you may inspect or receive a copy of such report. A summary of your rights may be found on the Internet at www.ftc.gov/credit.

USA PATRIOT Act Notice
The USA PATRIOT Act requires that we establish an Anti-Money Laundering (AML) Program, notify customers that we must verify the identity of the owner(s) of our contracts that have cash value, and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of issuance of coverage and may result in a decision not to accept your business.

Consent For Use Of Electronic Signatures and Records - Before we can process your application online, we will need you to sign it together with certain other documents. This process will bind your electronic "signature" to these documents such that no changes can ever be made to the information you provided without invalidating your signature. This provides you with the assurance that any information you provide will be retained exactly as you provided it - guaranteed! Also, please be assured that all of your information is subject to our strictest security and privacy standards. Click on the Security & Privacy link below for more information. Please read and acknowledge your consent to use electronic signatures and agreement to receive required notices and documents electronically.

Consent for use of electronic signatures and records:

American National Insurance Company is required by law to provide you with certain disclosures and information about your life insurance application ("Required Information"). With your consent, American National Insurance Company can deliver Required Information to you by: Displaying or delivering the Required Information electronically, and Requesting that you print or download the Required Information and retain it for your records.

This notice contains important information that you are entitled to receive before you consent to electronic delivery of required information. Your consent also permits the general use of electronic records and electronic signatures in connection with your application. Please read this notice carefully and print or download a copy for your files.

After you have read this information, if you agree to receive Required Information from American National Insurance Company electronically, and if you agree to the general use of electronic records and electronic signatures in connection with your relationship with American National Insurance Company, please click on the "Accept" button at the bottom.

Statement of electronic disclosures:

You may request to receive Required Information on paper, but if you do not consent to electronic delivery of Required Information, American National Insurance Company cannot proceed with the acceptance and processing of your electronic application.

If you consent to electronic delivery of Required Information, you may withdraw that consent at any time. However, if you withdraw your consent we will not be able to continue processing your application.

If you consent to electronic disclosures, that consent applies to all Required Information American National Insurance Company gives you or receives from you in connection with your life insurance application and the associated notices, disclosures, and other documents.

The Required Information that may covered by the consent includes, among other things:

Medical Information Bureau (MIB) Pre-Notification	Notice of Insurance Information Practices
Authorization to release personal health information	Notices regarding policy replacement and adverse underwriting decisions

You agree to print out or download Required Information when we advise you to do so and keep it for your records. If you have any trouble printing out or downloading any Required Information, you may call American National Insurance Company at 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time and request paper copies. If you need to update your e-mail address or other contact information with American National Insurance Company, you may do so by calling us at 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time or by clicking on the Contact Us link at the bottom and sending the required information via email. Upon receipt, we will update your records.

If you wish to withdraw your consent to electronic disclosures, you may do so by calling us at 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time or by clicking on the Contact Us link at the bottom and sending the request via email. After consenting to receive and deliver Required Information electronically, you may, upon request, obtain a paper copy of the Required Information by calling 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time.

Software and Hardware Requirements:

To access and retain Required Information from American National Insurance Company, you must:

1. Be able to view the disclosures on your monitor and send screen prints to your printer, which can be done with your browser.
2. Have access to an Internet service account and use Internet Explorer V4.0 and above or Netscape Navigator V4.x and above to receive required information
3. Be able to send and receive e-mail that contains hyperlinks to Websites in order for American National Insurance Company to deliver required information to you

If you do not have the required software and/or hardware, or if you do not wish to use electronic records and signatures for any other reason, you can request paper copies of the application document(s) to be sent to you by clicking on the Contact Us link at the bottom and sending us your request.

Your consent does not mean that American National Insurance Company must provide the Required Information electronically. American National Insurance Company may, at their option, deliver Required Information on paper if it chooses to do so. American National Insurance Company may also require that certain communications from you be delivered to American National Insurance Company on paper at a specified address.

I have read the information about the use of electronic records, disclosures, notices, and e-mail, and consent to the use of electronic records for the delivery of required information in connection with my life insurance application with American National Insurance Company. I have been able to view this information using my computer and software. I have an account with an internet service provider, and I am able to send e-mail and receive e-mail with hyperlinks to websites and attached files. I also consent to the use of electronic records and electronic signatures in connection with my life insurance application with American National Insurance Company in place of written documents and

handwritten signatures. I am consenting on behalf of all joint applicants identified in the application. I am authorized to consent on their behalf.

Appendix C -

Website template subject to change (indicated in red boxes below – header and footer):

AMERICAN NATIONAL

877.698.0987 | Live Support ONLINE

ABOUT US | FAQS | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE | 2 APPLY FOR INSTANT COVERAGE | 3 PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage

*All asterisked * fields must be completed.*

You are 20% complete

Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

Supply Your Information

First Name: * | Middle Initial: | Last Name: *

Primary Mailing Address: *

City: * | State: * | ZIP: *

Gender: * Male Female | Date of Birth: *

Phone #1: * | Phone #2:

Email Address: * | Coverage Amount: * | Have you smoked cigarettes in the last 12 months? * Yes No

Height: * ft. in. | Weight: * lbs | Social Security Number: * - -

U.S. Citizen: * Yes No | Marital Status: * Single Married

Occupation: * | Annual Household Income: * Select One

Choose Your Beneficiary

If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate.

First Name: | Middle Initial: | Last Name:

Relationship: Select One | Please Specify:* | Date of Birth:

Insurance Replacement

Do you intend to replace, discontinue, or change any existing life insurance policy? *

Yes No

Please Provide Information about the file insurance company that issued the policy or annuity you wish to replace:

Life Insurance Company Name: *

Policy or Contact Number: *

Coverage Amount: *

Proposed Insured

Is the person completing this application the proposed insured? *

Yes No

Automatic Premium Loan Requested

Automatic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be paid for you, automatically, by a loan against available cash value in your policy.

Select yes below to select this option.*

Yes No

CONTINUE

10498-C

AMERICAN NATIONAL

877.698.0987 | Live Support OFFLINE

ABOUT US | FAQS | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE | 2 APPLY FOR INSTANT COVERAGE | 3 PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage

You are 30% complete

Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

1. Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?
   - Yes
   - No

2. Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?
   - Yes
   - No

   Explain:

3. Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?
   - Yes
   - No

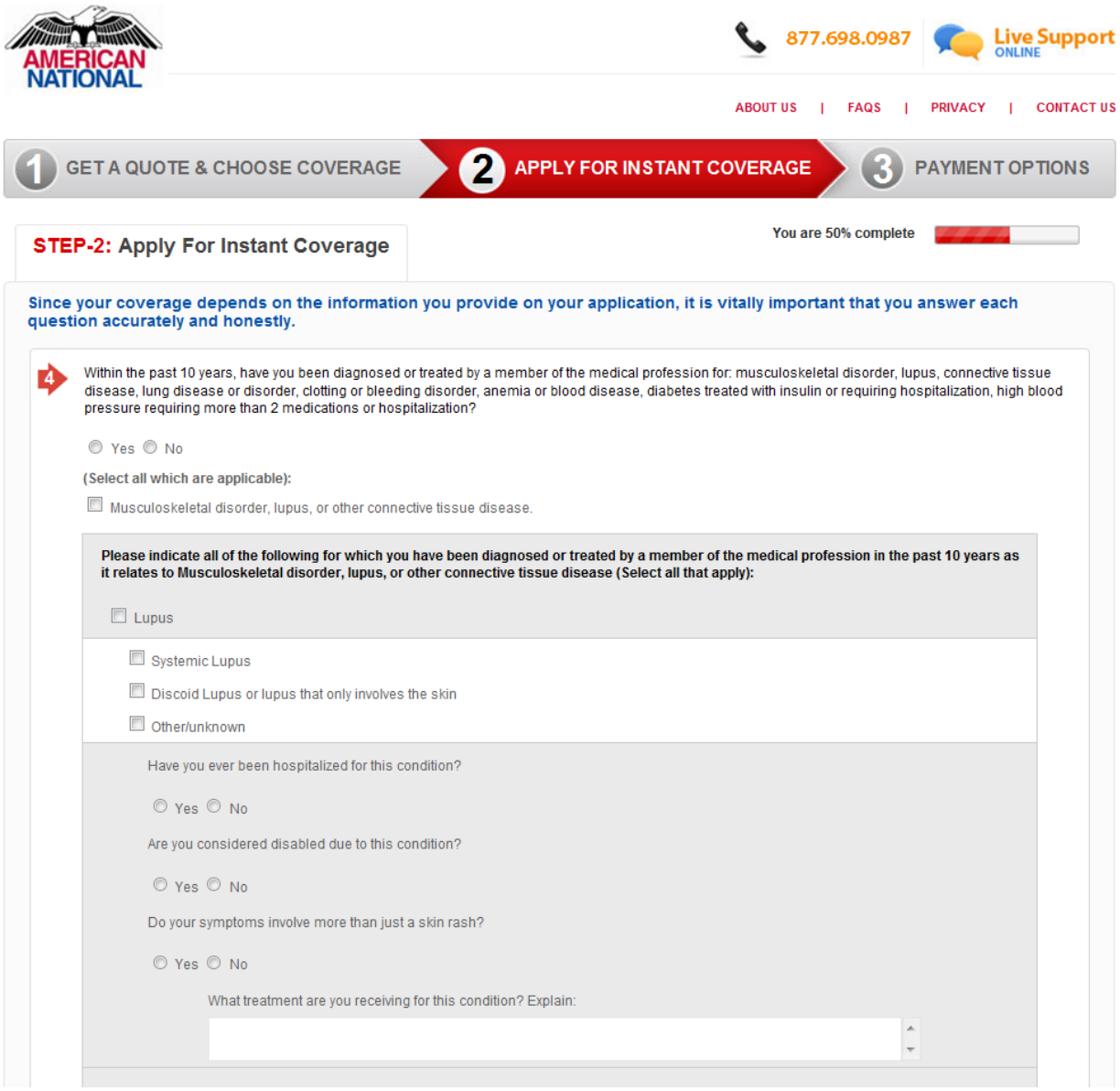
CONTINUE

American National Insurance Company, is headquartered in Galveston, TX and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, Glenmont, NY. Policies contain exclusions, limitations and terms for keeping them in force.

DISCOVER MasterCard VISA PayPal digicert SECURED ssl certificates This Page is Secured

10498-C

MQ2


AMERICAN NATIONAL
877.698.0987
Live Support ONLINE
ABOUT US | FAQS | PRIVACY | CONTACT US
1 GET A QUOTE & CHOOSE COVERAGE
2 APPLY FOR INSTANT COVERAGE
3 PAYMENT OPTIONS
STEP-2: Apply For Instant Coverage
You are 50% complete
Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.
4
Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization?
Yes No
(Select all which are applicable):
Musculoskeletal disorder, lupus, or other connective tissue disease.
Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to Musculoskeletal disorder, lupus, or other connective tissue disease (Select all that apply):
Lupus
Systemic Lupus
Discoid Lupus or lupus that only involves the skin
Other/unknown
Have you ever been hospitalized for this condition?
Yes No
Are you considered disabled due to this condition?
Yes No
Do your symptoms involve more than just a skin rash?
Yes No
What treatment are you receiving for this condition? Explain:

☐ Rheumatoid Arthritis

Are you considered disabled due to this condition?

○ Yes ○ No

Have you ever been hospitalized for this condition?

○ Yes ○ No

Do you require the walking aids or wheelchair?

○ Yes ○ No

Do you take steroids or Prednisone?

○ Yes ○ No

☐ Mixed Connective Tissue Disease

☐ Polymyositis or dermatomyositis

☐ Fibromyalgia

Are you currently being treated with steroids, Prednisone or narcotic pain medication?

○ Yes ○ No

☐ Tendonitis or tenosynovitis

☐ Gout

☐ Osteoarthritis

☐ Osteomyelitis

Is this a chronic condition?

○ Yes ○ No

Have you fully recovered?

○ Yes ○ No

Number of years since your last episode or attack?

○ 0 to 3 years

○ Over 3 years

☐ Herniated disc or back sprain

Do you currently require use of narcotic pain medication?

Yes No

☐ Osteoporosis

Does this condition cause any restrictions on activity or disability?

Yes No

☐ Paget's disease of the Bone

Does this involve more than 2 bones?

Yes No

Has this disease resulted in more than 1 fracture?

Yes No

Are there any restrictions on activity?

Yes No

Are you considered disabled due to this condition?

Yes No

☐ Benign, Non-malignant bone or joint tumor(s)

Have you fully recovered with no evidence of recurrence?

Yes No

Do you currently have any current tumor that has not been surgically removed?

Yes No

When was most recent tumor removed?

0 to 3 years

Over 3 years

☐ Malignant, cancerous bone or joint tumor(s)

☐ Polymyalgia Rheumatica

Have you had any treatment or symptoms within the past 2 years?

Yes No

☐ Other

Explain:

☐ Lung disease or disorder

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to lung disease or disorder (Select all that apply):

☐ Emphysema

☐ COPD (Chronic Obstructive Lung Disease) or Chronic Bronchitis

Have you smoked any tobacco products in the past 2 years?

○ Yes ○ No

Have you ever required oxygen treatment?

○ Yes ○ No

Have you been hospitalized in the past 5 years for COPD or chronic bronchitis?

○ Yes ○ No

Are you currently treated with oral steroids or Prednisone?

○ Yes ○ No

Do you currently have any restrictions on activity due to COPD or Chronic Bronchitis?

○ Yes ○ No

Are you considered disabled due to COPD or Chronic Bronchitis

○ Yes ○ No

☐ Asthma

Have you been hospitalized in past 2 years for asthma?

○ Yes ○ No

Are you treated by oral steroids or Prednisone?

○ Yes ○ No

Do you currently have any restrictions on activity due to asthma?

○ Yes ○ No

Are you considered disabled due to asthma?

Yes No

☐ Bronchiectasis

Have you ever required oxygen treatment?

Yes No

Have you been hospitalized for bronchiectasis in the past 5 years?

Yes No

Are you considered disabled due to bronchiectasis?

Yes No

Do you currently have any restrictions on activity due to bronchiectasis?

Yes No

☐ Bronchitis (non chronic)

☐ Pneumonia

Do you currently have pneumonia, have had pneumonia within the past 3 months or are recovering from pneumonia?

Yes No

Have you fully recovered from pneumonia and have no further symptoms?

Yes No

Have you been advised to have a follow-up Chest X-ray, CT-scan, MRI or other testing related to the lungs that has not been completed or that you are awaiting results?

Yes No

Do you have any other lung or heart problems?

Explain:

☐ Pneumothorax (collapsed lung)

Did the pneumothorax occur within the past 6 months?

Yes No

What was the cause of the pneumothorax?

- ○ Spontaneous
- ○ Trauma
- ○ Other

Explain:

Have you fully recovered from the pneumothorax with no further symptoms?

○ Yes ○ No

☐ Pulmonary embolism (blood clot in lung)

Have you had more than one episode/event associated with a pulmonary embolism?

○ Yes ○ No

Have you had a pulmonary embolism within the past 2 years?

○ Yes ○ No

Do you require ongoing anticoagulant treatment (Coumadin or Warfarin) to prevent future blood clots?

○ Yes ○ No

Was the cause of the embolism due to another disease or disorder?

○ Yes ○ No

Explain:

☐ Pulmonary Hypertension

☐ Sarcoidosis

☐ Sleep Apnea

Were you diagnosed with sleep apnea within the past 6 months?

○ Yes ○ No

Have you been advised to use c-pap or bi-pap treatment?

Yes No

Do you use recommended treatment?

Yes No

Have you been advised to have a sleep study that has not yet been completed?

Yes No

Do you currently suffer from excessive daytime fatigue?

Yes No

Lung cancer

Other

Explain:

Clotting or bleeding disorder, anemia or blood disease

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to clotting or bleeding disorder, anemia or blood disease (select all that apply)

Anemia

Have you been hospitalized for anemia in the past year?

Yes No

Has your anemia caused you to receive a blood transfusion in the past 5 years?

Yes No

Have you ever been diagnosed with cancer (excluding basal cell or squamous cell skin cancer), leukemia, lymphoma, multiple myeloma, or hemophilia or other bleeding/clotting disorder?

Yes No

Have you been diagnosed with sickle cell anemia?

Yes No

Have you been advised by a member of the medical profession that you have sickle cell trait only?

Yes No

Have you ever been diagnosed with symptomatic sickle cell anemia or required any treatment for sickle cell anemia?

Yes No

Was the cause of the anemia due to bleeding from the gastrointestinal tract?

Yes No

Was the last occurrence of gastrointestinal bleeding within the past 2 years?

Yes No

Was there any cancer or malignancy found to be the cause of the bleeding?

Yes No

Have the symptoms fully resolved and anemia no longer present?

Yes No

Have you had a colonoscopy with abnormal results in the past 2 years?

Yes No

Have you been advised to have a colonoscopy or other testing involving the gastrointestinal tract that has not yet been completed?

Yes No

Other

Explain:

Diabetes treated with insulin or requiring hospitalization

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to diabetes treated with insulin or requiring hospitalization (select all that apply)

Have you been prescribed Insulin to treat your diabetes?

Yes No

Have you been hospitalized in the past 5 years due to diabetes?

Yes No

Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?

Yes No

Have you been diagnosed by a member of the medical profession with heart disease, kidney disease, excessive protein or albumin in the urine, or blindness?

Yes No

Have you had any limbs amputated due to diabetes or circulatory problems?

Yes No

Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?

Yes No

What was your most recent Hemoglobain A1c (HGB A1c, glycosylated hemoglobin) test result?

- 7.0 or less
- 7.1 - 9.99
- 10.0 or higher
- unknown

What was your most recent blood sugar test result?

- Below 145
- 145 to 220
- Over 220

Have you been prescribed oral medications or diet to treat your diabetes?

Yes No

Have you been hospitalized in the past 5 years due to diabetes?

Yes No

Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?

Yes No

Have you had any limbs amputated due to diabetes or circulatory problems

Yes No

Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?

Yes No

What was your most recent Hemoglobain A1c (HGB A1c, glycosylated hemoglobin) test result?

7.0 or less

7.1 - 9.99

10.0 or higher

unknown

What was your most recent blood sugar test result?

Below 145

145 to 220

Over 220

High blood pressure requiring more than 2 medications or hospitalization

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to high blood pressure requiring more than 2 medications or hospitalization (select all that apply)

In the past 6 months have you had a blood pressure reading over 160/100?

Yes No

Have you ever been diagnosed with Stroke, Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA), Heart Disease, Congestive Heart Failure, Peripheral Vascular disease, or disease or disorder of the heart valves?

Yes No

Do you have any cardiac testing or procedures pending or advised to have completed that have not been completed?

Yes No

Explain:

5 Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?

○ Yes ○ No

(Select all which are applicable):

☐ Heart attack or any disease or abnormality of the heart or blood vessels.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to heart attack or disease or abnormality of the heart or blood vessels. (Select all that apply):

☐ Heart Attack

☐ Stroke or Cerebral Vascular Accident (CVA)

☐ Coronary Artery Disease

☐ Coronary Bypass surgery, coronary angioplasty, or Stinting of coronary artery or arteries.

☐ Congestive Heart Failure

☐ Disease of the heart valve or valves

☐ Heart Murmur

Does your heart murmur cause any restrictions on activity?

○ Yes ○ No

Have you ever had any blackouts or fainting episodes due to your heart murmur?

○ Yes ○ No

Have you ever been diagnosed by a member of the medical profession with a disease or disorder of the heart valves?

○ Yes ○ No

Have you been diagnosed with Mitral Valve Prolapse (MVP)?

○ Yes ○ No

Does your Mitral Valve Prolapse cause any arrhythmias or palpatations or restrict activity in any way?

○ Yes ○ No

When was your most recent echocardiogram (ultrasound of heart)?

- ○ within the last 6 months
- ○ over 6 months ago
- ○ never had an echocardiogram

Have you been advised to have an echocardiogram (ultrasound of heart) that has not yet been completed?

○ Yes ○ No

Do you have any other cardiac testing or procedures pending or advised to have completed that have not yet been completed?

○ Yes ○ No

Explain:

- ☐ Irregular heartbeat, palpatations, or arrhythmia
- ☐ High Blood Pressure or Hypertension
- ☐ Other

Explain:

- ☐ Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease.
- ☐ Cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy.
- ☐ Acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex.
- ☐ Tested positive on an acquired immune deficiency syndrome-related test.
- ☐ Nervous system disorder or disease.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply):

- ☐ Dementia or cognitive disease or disorder
- ☐ Huntington's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke or Cerebral Vascular Accident (CVA)
- ☐ Parkinson's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease
- ☐ Seizure disorder or epilepsy

Were you first diagnosed with seizure disorder or epilepsy within the past 2 years?

Yes No

When was your last attack/episode of epilepsy or seizure?

0-3 years ago

3-7 years ago

Over 7 years ago

Are you considered disabled due to seizure disorder or epilepsy?

Yes No

Is seizure disorder or epilepsy caused by a brain or other nervous system tumor?

Yes No

Do you have any testing or procedures that have been recommended by a member of the medical profession for seizure disorder or epilepsy that has not yet been completed?

Yes No

Explain:

Tremor

Has the tremor been present for less than 2 years?

Yes No

Has the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no Parkinson's disease or other underlying cause?

Yes No

Do you have any testing or procedures with respect to the tremor that have been recommended by a member of the medical profession that has not yet been completed?

Yes No

Explain:

Spinal Cord injury or disease

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to spinal cord injury or disease (Select all that apply):

- [ ] Quadriplegia or tetraplegia
- [ ] Paraplegia or Paraparesis
- [ ] Hemiplegia or hemaparesis
- [ ] Non-paralyzing injury to spinal cord
- [ ] Spondylosis
- [ ] Herniated disc or compression of the spinal cord
- [ ] Other Spinal Cord disease, disorder or injury

Explain:

Do you currently use a wheel chair?

( ) Yes ( ) No

Do you currently require the use of narcotics to control pain?

( ) Yes ( ) No

Do you currently require walking aids?

( ) Yes ( ) No

Are you considered disabled due to the spinal cord injury or disease?

( ) Yes ( ) No

- [ ] Tumor of the nervous system or brain

Was the tumor considered cancerous or malignant?

( ) Yes ( ) No

Was the tumor a brain tumor?

( ) Yes ( ) No

Has the brain tumor been surgically removed?

( ) Yes ( ) No

Was the brain tumor removed within the past 10 years?

( ) Yes ( ) No

Do you have any neurological testing or procedure that has been recommended by a medical professional that has not yet been completed?

( ) Yes ( ) No

Explain:

Was the tumor a spinal cord tumor?

Yes No

Was the tumor surgically removed

Yes No

Was the tumor removed within the past 2 years?

Yes No

Do you have any neurological testing or procedure that has been recommended by a medical professional that has not yet been completed?

Yes No

Explain:

Depression, Anxiety, or other psychological condition

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to depression, anxiety, or other psychological condition: (Select all that apply):

Bipolar

Schizophrenia

Depression

Have you been hospitalized for this condition in the past 5 years?

Yes No

Have you ever attempted suicide?

Yes No

Are you considered disabled due to this condition?

Yes No

Anxeity

Have you been hospitalized for this condition in the past 5 years?

Yes No

Have you ever attempted suicide?

Yes No

Are you considered disabled due to this condition?

Yes No

Other

Explain:

Bells Palsy

Have you been diagnosed by a member of the medical profession with Bells Palsy within the past 6 months?

Yes No

Trigeminal Neuralgia

Have you had surgery for trigeminal neuralgia?

Yes No

Have you fully recovered from the surgery?

Yes No

Has surgery been recommended that has not been completed?

Yes No

Thoracic Outlet Syndrome

Narcolepsy

Were you first diagnosed by a member of the medical profession with Narcolepsy within the past 2 years?

Yes No

Have you had any symptoms of narcolepsy in the past year?

Yes No

Other nervous system disorder or disease

Explain:

Hepatitis C or any kidney, liver, pancreas disease or disorder.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to hepatitis C or kidney, liver, pancreas disease or disorder. (Select all that apply): :

- [ ] Kidney Disease
  - [ ] Blockage of the renal (kidney) arteries
  - [ ] Hypertensive renal (kidney) disease
  - [ ] Cancer of the kidney
  - [ ] Had dialysis or been advised to have dialysis?
  - [ ] Kidney failure
  - [ ] Glomerulonephritis, nephritic or nephrotic syndrome
  - [ ] Polycystic kidney disease
  - [ ] Kidney stones
  - [ ] Kidney infection
    - Did your kidney infection occur in the past 3 months?
      - ( ) Yes ( ) No
      - Have you fully recovered from your kidney infection
        - ( ) Yes ( ) No
  - [ ] Other
    - Explain:
- [ ] Hepatitis B or C
- [ ] Hepatitis A
  - Have you fully recovered from Hepatitis A?
    - ( ) Yes ( ) No
- [ ] Non-viral hepatitis
- [ ] Enlarged liver
- [ ] Cirrhosis of the liver
- [ ] Primary Biliary Cirrhosis
- [ ] Primary Sclerosing Cholangitis
- [ ] Liver tumor or liver cancer

☐ Fatty liver

Have you been advised by member of the medical profession that your liver enzymes or liver function tests are abnormal or elevated?

◯ Yes ◯ No

Have you been advised by a member of the medial profession that the cause of fatty liver is related to alcohol use?

◯ Yes ◯ No

Have you had a liver biopsy or has a liver biopsy been recommended by a member of the medical profession?

◯ Yes ◯ No

Have you been diagnosed by a member of the medical profession with Non-Alcoholic Steatohepatitis (NASH)?

◯ Yes ◯ No

☐ Pancreatitis

☐ Tumor or Cancer of the Pancreas

☐ Crohn's or ulcerative colitis

Do you use steroids or immunosuppressive drugs for treatment?

◯ Yes ◯ No

Have you been hospitalized for Crohn's or ulcerative colitis in the past 5 years?

◯ Yes ◯ No

Did you require surgery or have you been advised by a member of the medical profession to have surgery for Crohn's or ulcerative colitis which has not been performed?

◯ Yes ◯ No

Have you had an attack of Crohn's or ulcerative colitis within the past year?

◯ Yes ◯ No

Does Crohn's or ulcerative colitis limit normal activity or are you considered disabled due to this condition?

◯ Yes ◯ No

Has a member of the medical profession advised you to have a colonoscopy or other test related to the gastrointestinal tract that has not been completed?

◯ Yes ◯ No

☐ Other

Explain:

☐ Alzheimer's, schizophrenia, bipolar or mental disorder.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to alzheimer's, schizophrenia, bipolar or mental disorder (select all that apply) :

☐ Alzheimer's
☐ Schizophrenia
☐ Bipolar
☐ Attempted Suicide
☐ Depression

Have you been hospitalized for this condition in the past 5 years?

○ Yes ○ No

Have you ever attempted suicide?

○ Yes ○ No

Are you considered disabled due to this condition?

○ Yes ○ No

☐ Anxiety

Have you been hospitalized for this condition in the past 5 years?

○ Yes ○ No

Have you ever attempted suicide?

○ Yes ○ No

Are you considered disabled due to this condition?

○ Yes ○ No

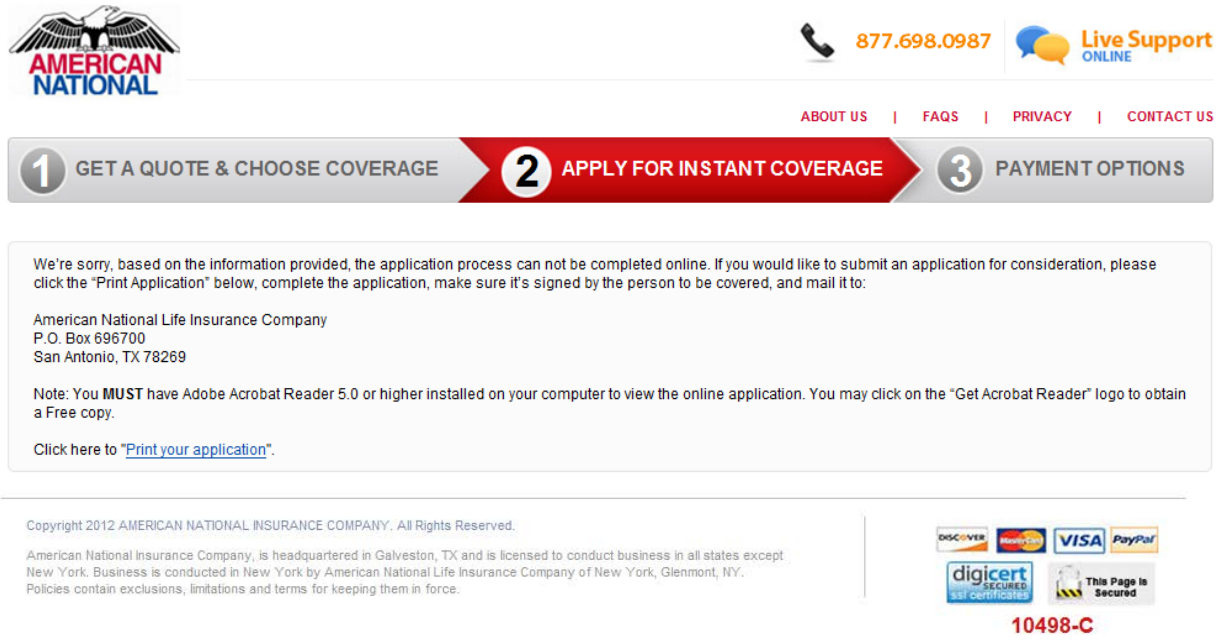
☐ Other

Explain:

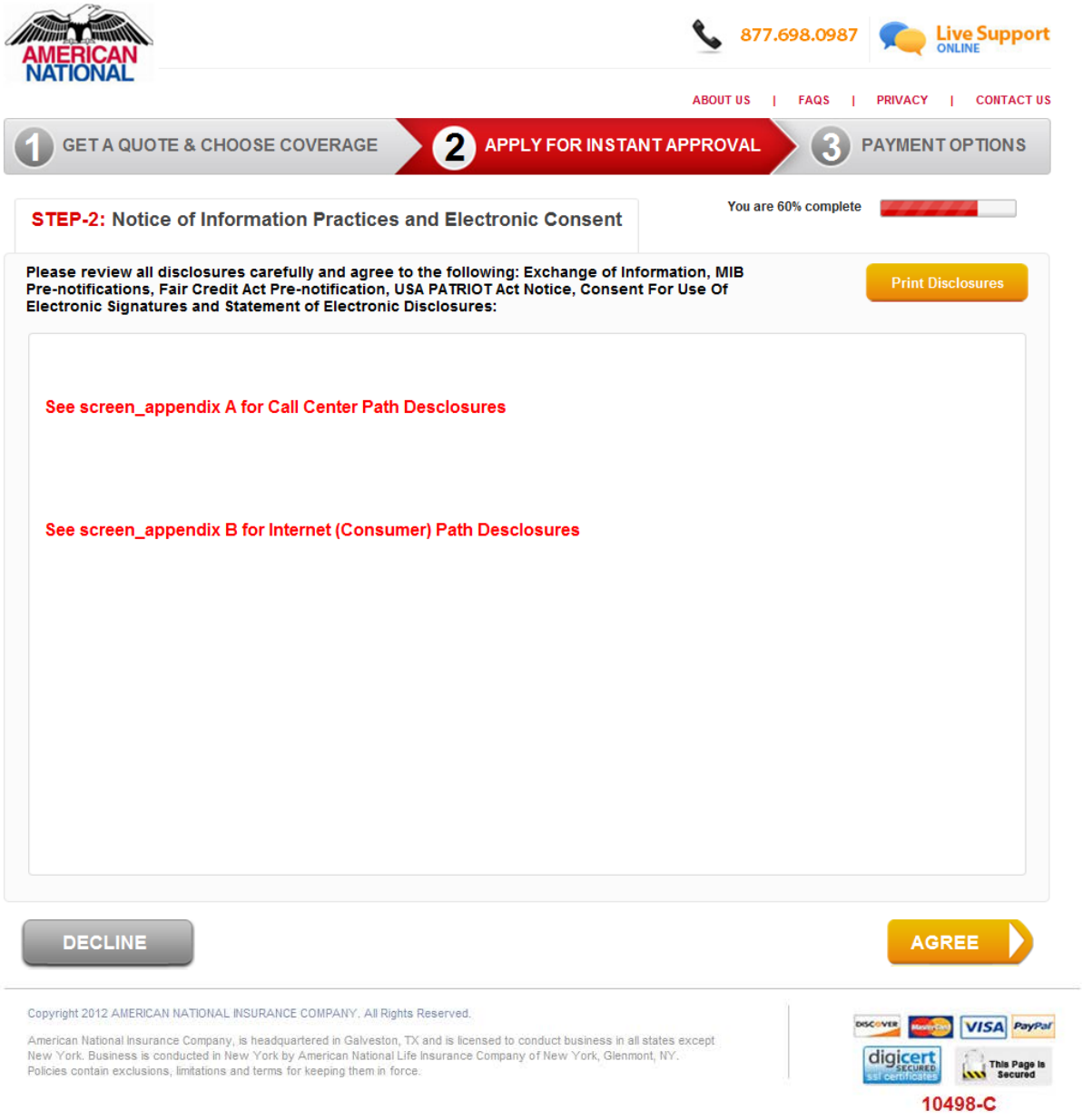
CONTINUE

10498-C

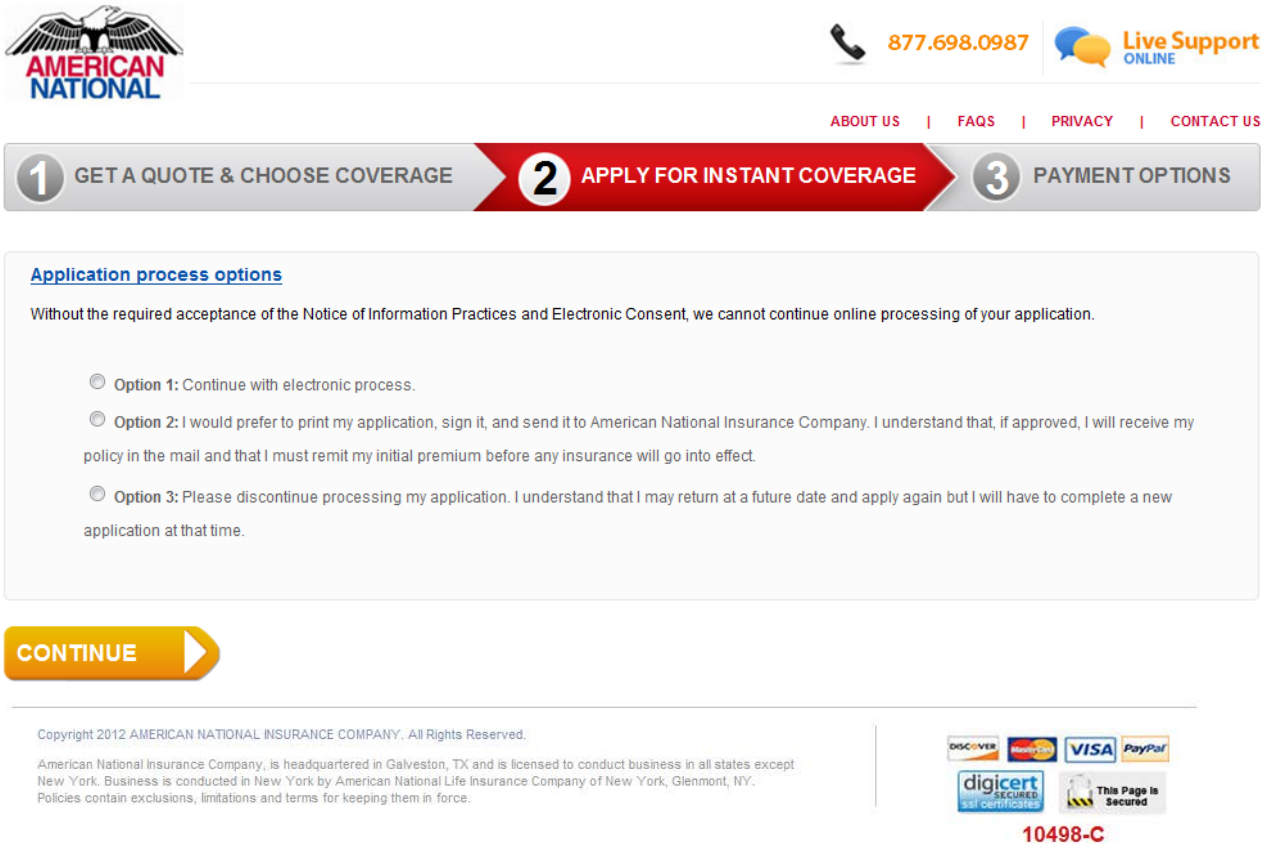
If med question decline:



Disclosure Page

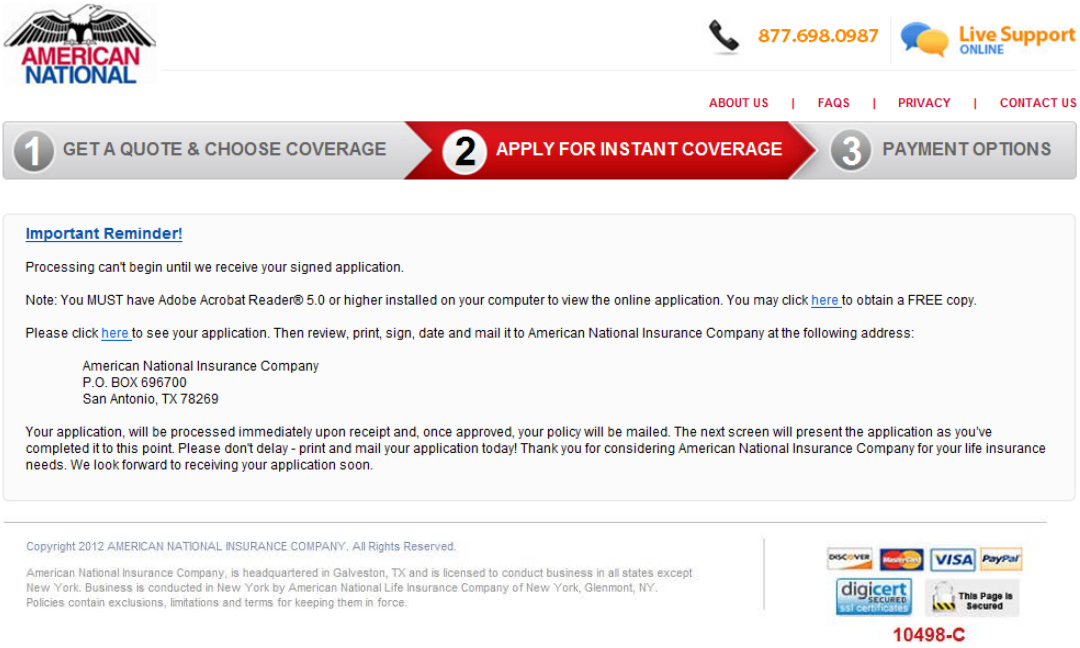


If decline –

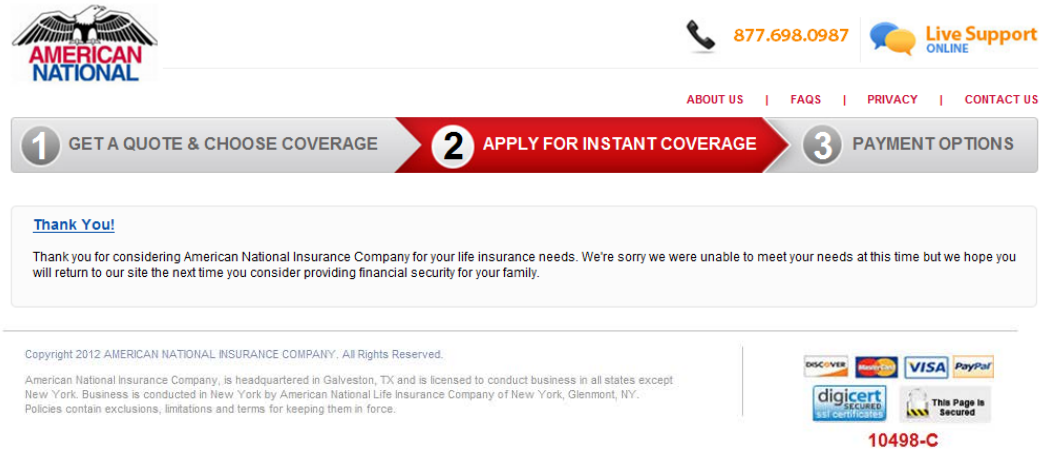


Ex opt 1 – go to Disclosure Page

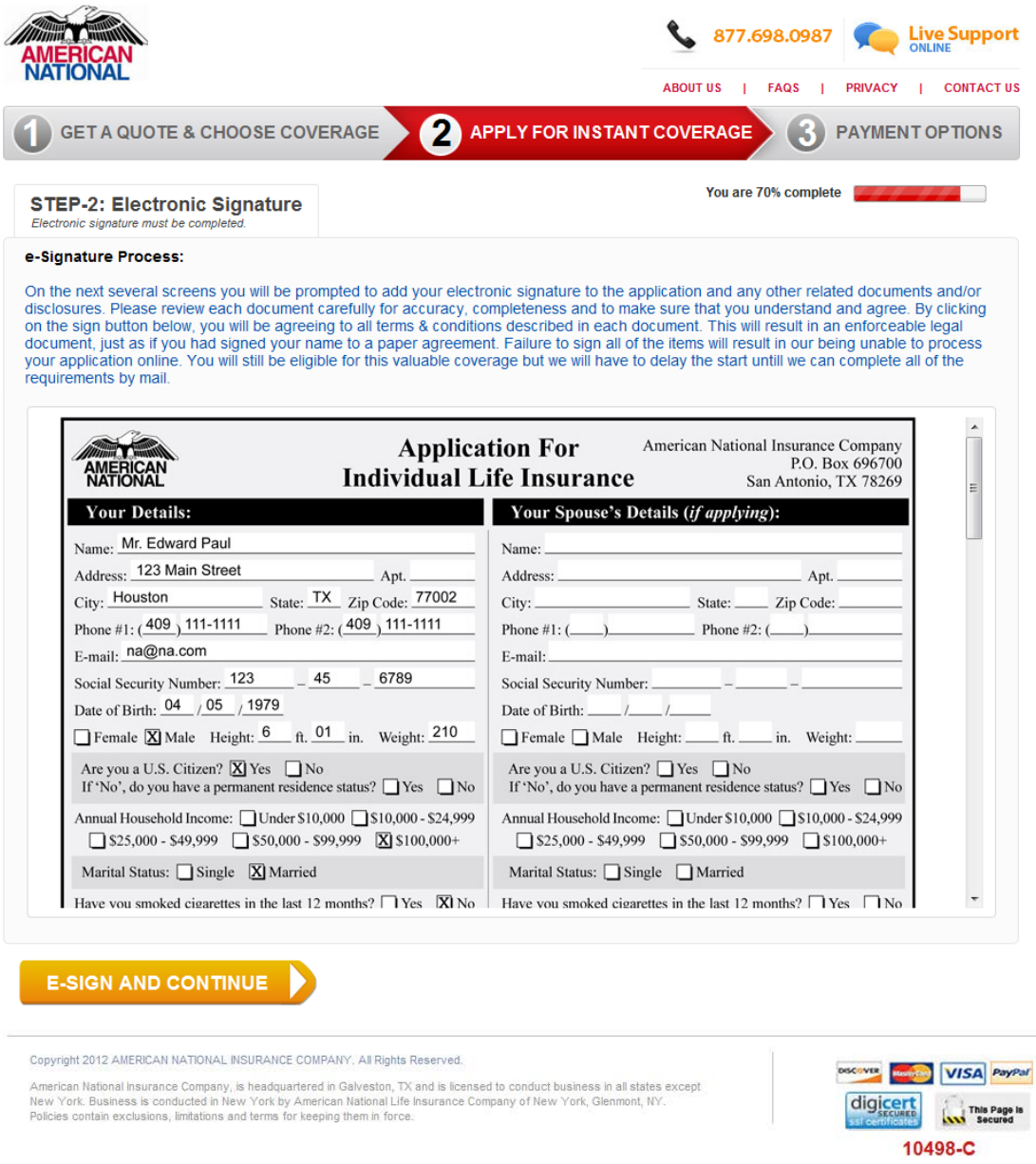
Ex opt 2 –



Ex opt 3 –

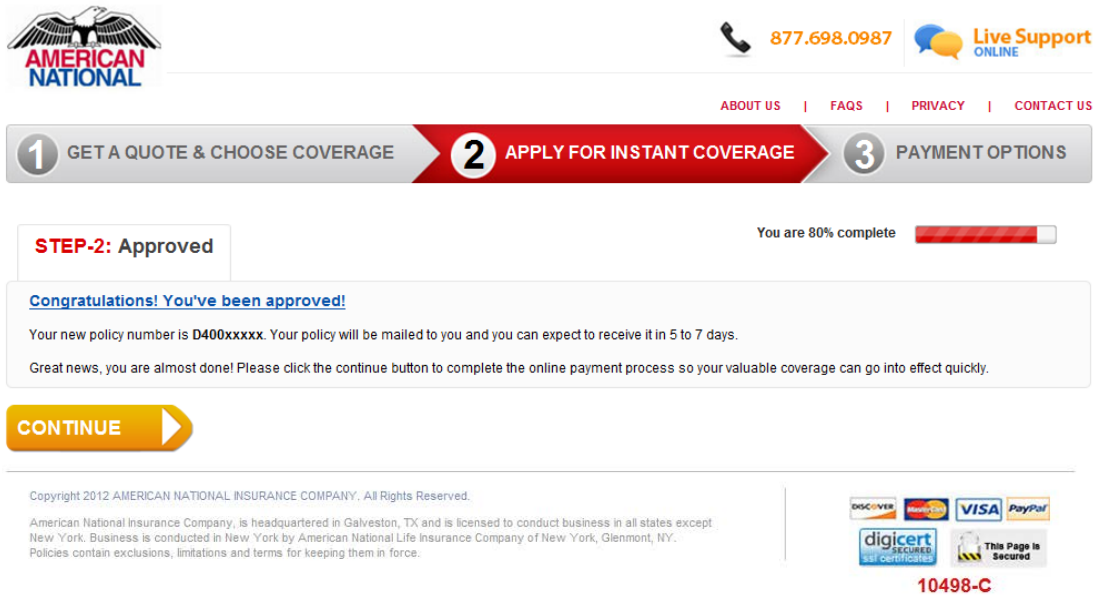


If agree from Disclosure Page – App is scrollable to review entire app (top of app)



Bottom of app… cont…

Approve –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877.698.0987
Live Support ONLINE
ABOUT US | FAQS | PRIVACY | CONTACT US
1 GET A QUOTE & CHOOSE COVERAGE
2 APPLY FOR INSTANT COVERAGE
3 PAYMENT OPTIONS
STEP-2: Approved
You are 80% complete
Congratulations! You've been approved!
Your new policy number is D400xxxxx. Your policy will be mailed to you and you can expect to receive it in 5 to 7 days.
Great news, you are almost done! Please click the continue button to complete the online payment process so your valuable coverage can go into effect quickly.
CONTINUE
Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.
American National Insurance Company, is headquartered in Galveston, TX and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, Glenmont, NY.
Policies contain exclusions, limitations and terms for keeping them in force.
DISCOVER MasterCard VISA PayPal
digicert SECURED ssl certificates
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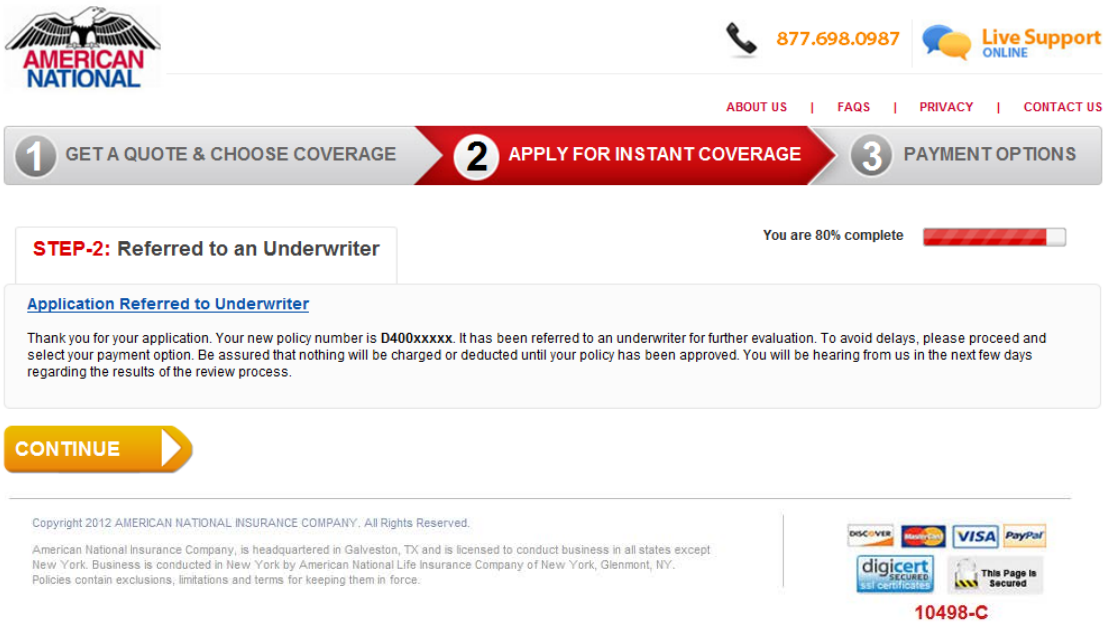
10498-C

RTU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ABOUT US | FAQS | PRIVACY | CONTACT US
1 GET A QUOTE & CHOOSE COVERAGE
2 APPLY FOR INSTANT COVERAGE
3 PAYMENT OPTIONS
STEP-2: Referred to an Underwriter
You are 80% complete
Application Referred to Underwriter
Thank you for your application. Your new policy number is D400xxxxx. It has been referred to an underwriter for further evaluation. To avoid delays, please proceed and select your payment option. Be assured that nothing will be charged or deducted until your policy has been approved. You will be hearing from us in the next few days regarding the results of the review process.
CONTINUE
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American National Insurance Company, is headquartered in Galveston, TX and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, Glenmont, NY.
Policies contain exclusions, limitations and terms for keeping them in force.
DISCOVER MasterCard VISA PayPal
digicert SECURED ssl certificates
This Page is Secured
10498-C

Final Application signed –

AMERICAN NATIONAL

Application For Individual Life Insurance

American National Insurance Company
P.O. Box 696700
San Antonio, TX 78269

Your Details:

Name: Mr. Edward Paul
Address: 123 Main Street Apt. ____
City: Houston State: TX Zip Code: 77002
Phone #1: (409) 111-1111 Phone #2: (409) 111-1111
E-mail: na@na.com
Social Security Number: 123 – 45 – 6789
Date of Birth: 04 / 05 / 1979
☐ Female ☒ Male Height: 6 ft. 01 in. Weight: 210

Are you a U.S. Citizen? ☒ Yes ☐ No
If 'No', do you have a permanent residence status? ☐ Yes ☐ No

Annual Household Income: ☐ Under $10,000 ☐ $10,000 - $24,999
☐ $25,000 - $49,999 ☐ $50,000 - $99,999 ☒ $100,000+

Marital Status: ☐ Single ☒ Married

Have you smoked cigarettes in the last 12 months? ☐ Yes ☒ No
Occupation: franchise owner

Your Spouse's Details (*if applying*):

Name: ____
Address: ____ Apt. ____
City: ____ State: ____ Zip Code: ____
Phone #1: (____)____ Phone #2: (____)____
E-mail: ____
Social Security Number: ____ – ____ – ____
Date of Birth: ____ / ____ / ____
☐ Female ☐ Male Height: ____ ft. ____ in. Weight: ____

Are you a U.S. Citizen? ☐ Yes ☐ No
If 'No', do you have a permanent residence status? ☐ Yes ☐ No

Annual Household Income: ☐ Under $10,000 ☐ $10,000 - $24,999
☐ $25,000 - $49,999 ☐ $50,000 - $99,999 ☐ $100,000+

Marital Status: ☐ Single ☐ Married

Have you smoked cigarettes in the last 12 months? ☐ Yes ☐ No
Occupation: ____

Your Amount of Coverage & Beneficiary:

Plan: BudgetGuard 7 Year Term
Amount (choose one):
☐ $xxx,xxx ☐ $xxx,xxx
☐ $xxx,xxx ☒ Other: $ 25,000.00

Beneficiary: Ruth Paul
Date of Birth: 03 / 10 / 1980 Relationship: Spouse
Automatic Premium Loan Provision Requested? ☐ Yes ☒ No

IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☒ No
If 'Yes', name of company and policy number(s) if available:

Your Spouse's Coverage & Beneficiary:

Plan: ____
Amount (choose one):
☐ $xxx,xxx ☐ $xxx,xxx
☐ $xxx,xxx ☐ Other: $ ____

Beneficiary: ____
Date of Birth: ____ / ____ / ____ Relationship: ____
Automatic Premium Loan Provision Requested? ☐ Yes ☐ No

IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☐ No
If 'Yes', name of company and policy number(s) if available:

Your Health:

Your Spouse's Health (*if applying*):

1. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?

You ☐ Yes ☒ No **Your Spouse** ☐ Yes ☐ No

10498-AR

continued on back...

ADLAXXXX

Your Health:	Your Spouse's Health (*if applying*):

2. Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?

You ☐ Yes ☒ No | **Your Spouse** ☐ Yes ☐ No

3. Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?

You ☐ Yes ☒ No | **Your Spouse** ☐ Yes ☐ No

4. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization? If "Yes", provide details below (dates of treatment, test results, diagnoses, medications, etc.)

You ☐ Yes ☒ No Details: _____ | **Your Spouse** ☐ Yes ☐ No Details: _____

5. Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? If "Yes", provide details below:

You ☐ Yes ☒ No Details: _____ | **Your Spouse** ☐ Yes ☐ No Details: _____

If you have more details, please include them on a separate sheet of paper

Your Payment — choose one:

I/we authorize the collection of premiums for the policy or policies as follows.

1. ☐ Automatic monthly deductions from my checking or savings account.
   (Enclose a voided check when providing checking account and a deposit slip when providing savings account.)
2. ☐ Charge monthly premiums to my: ☐ Visa ☐ MasterCard ☐ Discover ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐/☐☐
   (Account Number) (Exp. Date)
3. ☐ Bill me/us. (Send no money now.)

Agreements and Your Authorization to Obtain, Release and Disclose Medical Information:

I understand and agree: that the answers in this application are, to the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due is paid in full while I am alive and in the same health condition as described above; that if my spouse and I request life insurance on this application that my personal financial and health information written on it will be made part of the policy issued to not only me but also my spouse; and that if I do not agree, I may contact the Company and receive a separate application.

I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, the Medical Information Bureau (MIB) or other organization that has any records concerning health or medical care, advice or treatment provided to me to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.

• I acknowledge receiving the Exchange of Information Notice.

• **Fraud Warning**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your Signature: X E-Signed 01/01/2012 by Edward Paul

Date: X 01 / 01 / 2012

Your Spouse's Signature: X _____

Date: X ____/____/____

Screen appendix A – Call Center Path

Exchange of Information, Medical Information Bureau, Inc. Pre-notifications, Fair Credit Reporting Act and USA Patriot Act Notices: -

Exchange of Information Notice

We are required to provide the following disclosures to you: Medical Information Bureau, Inc. (MIB) Pre-Notification Information regarding your insurability will be treated as confidential. American National Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. American National Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification

We may obtain an investigative consumer report in connection with your application. This report may contain information about your character, general reputation, personal characteristics or mode of living gathered from personal interviews with persons who may be acquainted with you. The information is kept confidential. You have the right to additional information about the nature and scope of the investigation provided you submit your request in writing within a reasonable period of time. We will inform you whether an investigative consumer report was requested and provide you with contact information for the agency preparing the report. By contacting the agency and providing proper identification, you may inspect or receive a copy of such report. A summary of your rights may be found on the Internet at www.ftc.gov/credit.

USA Patriot Act Notice

The USA Patriot Act requires that we establish an Anti-Money Laundering ('AML') Program, notify customers that we must verify the identity of the owner(s) of our contracts that have cash value, and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of issuance of coverage and may result in a decision not to accept your business.

Consent For Use Of Electronic Signatures and Records

American National Insurance Company is required by law to provide you with certain disclosures and information about your life insurance application. This part of the notice requires you to consent to the use of electronic signatures in connection with your application. This consent will allow the representative to electronically sign on your behalf, the application documents for which you have just provided information. Even if you consent to use electronic signatures, paper copies of the application documents will be sent to you with your policy for your review.

Application Disclosure

You understand and agree: that the answers in this application are, to the best of your knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability
until a policy is issued and the first premium due is paid in full while you are alive and in the same health condition as described above; that if your spouse and you request life insurance on this application that your personal financial and health information written on it will be made part of the policy issued to not only you but also your spouse; and that if you do not agree, you may contact the Company and receive a separate application.

You authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, the Medical Information Bureau (MIB) or other organization that has any records concerning health or medical care, advice or treatment provided to you to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). You authorize the Company, or its reinsurers, to make a brief report of your personal health information to MIB. You understand: that the Company will use this information to determine your eligibility for life insurance and the premium amount; that you may refuse to sign this authorization and that your refusal will affect your ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that you have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.

You acknowledge receiving the Exchange of Information Notice.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Appendix C -

Website template subject to change (indicated in red boxes below – header and footer):

ANICO Direct Processes:

As a Direct Marketing division, we send Direct Marketing solicitations to perspective clients through direct mail and electronic media (Email, Banners, SEO, SEM, Aggregators and Call Centers).

Electronic Media process:

- The primary path for the customer is to click on a link within the appropriate media and to enter ANICO Direct's website where if they make a decision to receive a rate quote they proceed to the customer portal.
- The secondary path for the customer is to call on the phone number that is provided within the email or website. There, they can speak to a live person to discuss their needs and complete the process online with a licensed agent.

Direct Mail process:

- The primary path for the customer is to fill out the application and send it to American National for processing.
- As a secondary path, the customer is provided with a URL within the letter; the URL allows the customer to go to ANICO Direct's website where if they make a decision to receive a rate quote, they proceed to the customer portal.
- An additional secondary path is that the customer is also provided with the call center phone number, where they can speak to a live person to discuss their needs and complete the process online with a licensed agent.

The tools used to complete the process online is either a Call Center portal (completed by our call center agents) or the Customer path (completed by the customer applying for the product).

Call Center portal:

- When a customer calls our call center, we have the ability to help them by taking them through the Path which we refer to as the call center portal. In order to write the business for the customer, the agent must be licensed in that state. Within the portal, there is a validation against the licensing system to validate the licensing.
- The process, where necessary, is tailored for the agent to read the disclosures on the screen as a script, with the customers consent to complete the process on their behalf.
- The process also has embedded recordings, since disclosures can be state specific, the portal uses the insured state to queue the appropriate recording to ensure consistency with the disclosures.
- Once the questions and disclosures are completed, the application is generated in Silanes for an e-signature process. The e-signature process is approved by the customer and recorded for validation with a process called CVR (Continuous Voice Recording). The e-signature process is a secured signature process confirming acknowledgement of the application.
- CVR records the entire conversation through a vendor called Verint. The database is completely secured with read-only access to the data base to pull the recordings for review. In order to easily identify the recording, the agent "tags" the conversation with software called TagIt. The policy number is entered into TagIt to identify the recording.

Customer portal:

- They potential customer enters data into a series of data fields, selects the product they are interested in and are asked a series of medical questions. They are then presented with disclosures to agree to. Their responses to the fields and medical questions are saved to a database that is later used to populate the application for signature.
- Once the questions and disclosures have been completed, the application is generated in Silanes for an e-signature process. The e-signature process is approved and completed by the customer. All policies written through the tools above are sent to the administration system for processing.

Administration:

- Once the case is assigned a policy number and signed, the case is sent to the Administration system that will process the application. The final disposition of the case is determined and correspondence is sent from that system. The final correspondence will either be a bill and policy or a decline letter.